

CRS Report for Congress

Veterans' Health Care Issues

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Sidath Viranga Panangala
Analyst in Veterans Policy
Domestic Social Policy Division



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Committees of Congress

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Veterans' Health Care Issues

Summary

The Department of Veterans Affairs (VA) provides services and benefits to veterans who meet certain eligibility criteria. VA carries out its programs nationwide through three administrations and the Board of Veterans Appeals (BVA). The Veterans Health Administration (VHA) is responsible for veterans' health care programs. The Veterans Benefits Administration (VBA) is responsible for providing compensation, pensions, and education assistance, among other things. The National Cemetery Administration's (NCA) responsibilities include maintaining national veterans cemeteries.

VHA operates the nation's largest integrated health care system. Unlike most other federal health programs, VHA is a direct service provider rather than a health insurer or payer for health care. VA health care services are generally available to all honorably discharged veterans of the U.S. Armed Forces who are enrolled in VA's health care system. VA has a priority enrollment system that places veterans in priority groups based on various criteria. Under the priority system, VA decides each year whether its appropriations are adequate to serve all enrolled veterans. If not, VA could stop enrolling those in the lowest-priority groups.

Since the terrorist attacks of September 11, 2001, U.S. Armed Forces have been deployed in two major theaters of operation. Operation Enduring Freedom (OEF) in Afghanistan and Operation Iraqi Freedom (OIF) constitute the largest sustained ground combat mission undertaken by the United States since the Vietnam War. Veterans from these conflicts and from previous wars are exerting tremendous stress on the VA health care system. With increased patient workload and rising health care costs, the 110th Congress is focused on such issues as how to contain costs and at the same time maintain high-quality health care services to veterans who need them. Among other things, Congress may address the best method of funding for veterans' health care, while continuing to focus on ensuring a "seamless transition" process for servicemembers moving from the military health system into the VA health care system, improving mental health care services for veterans with Post Traumatic Stress Disorder (PTSD), and improving rehabilitation and mental health services for those with Traumatic Brain Injuries (TBI).

In recent years, VA has made an effort to realign its capital assets, primarily its buildings, to better serve veterans' needs. VA established the Capital Asset Realignment for Enhanced Services (CARES) initiative to identify how well the geographic distribution of VA health care resources matches the projected needs of veterans. Given the tremendous interest in the implementation of the CARES initiative in the previous Congress, the 110th Congress will likely continue to monitor the CARES implementation. H.R. 327 was enacted into law (P.L. 110-110) on November 5. The House has passed several measures to improve and expand health care services to veterans: H.R. 327, H.R. 612, H.R. 1315, H.R. 1470, H.R. 2199, H.R. 2623, and H.R. 2874. The Senate VA Committee has reported the following measures: S. 1233, S. 2004, S. 2142, S. 2160, and S. 2162.

This report will be updated as legislative activities warrant.

Contents

Introduction	1
Overview	1
Historical Background	2
Department of Veterans Affairs (VA)	2
Veterans' Health Care System	3
Veterans Health Information Systems and Technology Architecture (VistA)	4
Veteran Population	7
Eligibility for Veterans' Health Care	10
"Promise of Free Health Care"	10
VHA Health Care Enrollment	11
Veteran's Status	13
Priority Groups	13
Health Services	14
Medical Care for Returning Injured Servicemembers	15
Overview	15
OEF and OIF Veterans	16
Transition Issues	20
Initial Medical Care in DOD Facilities	21
Transfer and Care in VA Facilities	22
VA Activities to Assist OEF and OIF Servicemembers	26
VA-DOD Joint Executive Committee	27
Office of Seamless Transition	27
Vet Centers	28
Exchange of Health Information	30
Veterans Tracking Application (VTA)	32
Two-Year Eligibility for Veterans Returning from Iraq and Afghanistan	33
Task Force on Returning Global War on Terror Heroes	33
Other Health Care Issues	34
Post-Traumatic Stress Disorder (PTSD)	34
OEF/OIF PTSD Data and Trends	34
VA treatment programs for PTSD	35
Traumatic Brain Injury (TBI)	36
OEF/OIF TBI Data	36
VA Treatment of TBI	37
Mandatory Funding for Veterans' Health Care	37
Continued Suspension of Priority Group 8 Veterans	39
Filling of Privately Written Prescriptions at VA	40
Capital Asset Realignment for Enhanced Services (CARES)	41
Beneficiary Travel Program	48
Veterans Health Care Legislation	50
Health Care Legislation Enacted into Law	50

Joshua Omvig Veterans Suicide Prevention Act (H.R. 327, H.Rept. 110-055, P.L. 110-110)	50
Health Care Legislation Passed by the House	51
Returning Servicemember VA Healthcare Insurance Act of 2007 (H.R. 612)	51
Chiropractic Care Available to All Veterans Act (H.R. 1470)	51
Traumatic Brain Injury Health Enhancement and Long-Term Support Act of 2007 (H.R. 2199, H.Rept. 110-166)	51
Veterans Benefit Improvement Act of 2007 (H.R. 1315, H.Rept. 110-266)	51
Veterans Health Care Improvement Act of 2007 (H.R. 2874, H.Rept. 110-268)	51
Prohibit the collection of copayments for all hospice care provided by the VA (H.R. 2623, H.Rept. 110-267)	52
Health Care Legislation Reported in the Senate	53
Veterans Traumatic Brain Injury and Health Programs Improvement Act of 2007 (S. 1233, S.Rept. 110-147)	53
Appendix. Priority Groups and Their Eligibility Criteria	55

List of Figures

Figure 1. Veterans Integrated Services Networks (VISNs)	6
Figure 2. Veteran Population by State as of September 30, 2006 (in thousands)	8
Figure 3. Percent of Veterans Enrolled in the VA Health Care System by VISN, FY2005	9
Figure 4. Number of Patients by VISN, FY2005	9
Figure 5. Frequency of Major Diagnoses among OEF and OIF Veterans	17
Figure 6. Cumulative Number of OIF and OIF Veterans Discharged from FY2002-FY2006	18
Figure 7. Cumulative Unique OIF and OEF Veteran Patients and OIF and OEF Discharges from FY2002 thru FY2006 Compared with Annual Number of Unique Patients	19
Figure 8. Current Level of Care from Injury to Definitive Care	22
Figure 9. DOD and VA Electronic Information Sharing Focus Areas	31
Figure 10. Milestones and Plans for Exchange of Medical Information	32

List of Tables

Table 1. Health Enrollment Process	12
Table 2. VA Spending and Number of OIF and OEF Veteran Patients	20
Table 3. VHA's Polytrauma System of Care	24
Table 4. Impact of Priority Group 8 Suspension, FY2003-FY2008	40
Table 5. Timeline of Major CARES Activities	44
Table 6. CARES Decisions on the 18 Sites	46
Table 7. Veterans Eligible for Travel Benefits	50

Veterans' Health Care Issues

Introduction

Overview

This report provides an overview of major issues facing veterans' health care during the 110th Congress. The report's primary focus is on *veterans* and not *military retirees*. While any person who has served in the armed forces of the United States is regarded as a veteran, a military retiree is someone who has generally completed a full active duty military career (almost always at least 20 years of service), or who is disabled in the line of military duty and meets certain length of service and extent of disability criteria, and who is eligible for retired pay and a broad range of nonmonetary benefits from the Department of Defense (DOD) after retirement. A veteran is someone who has served in the armed forces (in most, but not all, cases for a few years in early adulthood), but may not have either sufficient service or disability to be entitled to post-service retired pay and nonmonetary benefits from DOD.¹ *Generally, all military retirees are veterans, but not all veterans are military retirees.* For the purposes of veterans' benefits, a veteran is defined as a person who served in the active military, naval, or air service, and who was discharged or released under conditions other than dishonorable.²

Currently, there are two health care systems that care for servicemembers and veterans. The Defense Health Program (DHP) in the DOD provides for worldwide medical and dental services to active duty military personnel, and other eligible beneficiaries.³ Once they are discharged from their respective service branches, servicemembers become eligible for care and treatment provided by the Department of Veterans Affairs (VA). Prior to discussing major health care issues, this report provides a brief overview of the VA, the Veterans Health Administration (VHA) within the VA which oversees the largest integrated health care system in the country, and the veteran population it serves.⁴ To provide context to the issues

¹ For detailed reports on benefits available for military retirees, see CRS Current Legislative Issue "U.S. Military Personnel and Compensation" under "Defense," at [<http://www.crs.gov/>].

² 38 U.S.C. §101; 38 CFR §3.1. Also see CRS Report RL33113, *Veterans Affairs: Basic Eligibility for Disability Benefit Programs*, by Douglas Reid Weimer.

³ For details on the Defense Health Program, see CRS Report RL33537, *Military Medical Care: Questions and Answers*, by Richard A. Best Jr.

⁴ For detailed information on veterans' benefits issues see, CRS Report RL33985, *Veterans' (continued...)*

discussed in the second part of this report, a basic overview of eligibility for health care under the veterans health care system is presented.

Historical Background

Beginning with the early colonial settlements of America, the nation has provided benefits in varying degrees to those who have worn the uniform and suffered physical disabilities in service to the nation. For instance, in 1718, the colony of Rhode Island enacted legislation that provided benefits not only to every officer, soldier or sailor who served in the colony's armed services, but also to the wives, children, parents, and other relations who had been dependent upon a slain servicemember. "The physically disabled were to have their wound carefully tended and healed at the colony's expense, while at the same time an annual pension was provided to him out of the general treasury sufficient for the maintenance of himself and family, or other dependent relatives."⁵

While pension and disability benefits provided to veterans were gradually increased and in some cases decreased since the early colonial period, hospital and medical care for veterans on a level similar to the care provided today was not available until World War I. The VA health care system has evolved and expanded since World War I. Congress has enlarged the scope of the VA's health care mission, and has enacted legislation requiring the establishment of new programs and services. Through numerous laws, some narrowly focused, and others more comprehensive, Congress has also extended to additional categories of veterans eligibility for the many levels of care the VA now provides. No longer a health care system focused only on service-connected veterans, the VA has become a "safety net" for the many lower-income veterans who have come to depend upon it.⁶ Furthermore, with the fragmented private-sector health care system, the lack of universal access to health care services, and the growing number of people joining the ranks of the uninsured, many veterans — even some with private health insurance — have chosen to receive care through the VA.⁷

Department of Veterans Affairs (VA)

The history of the present-day VA can be traced back to July 21, 1930, when President Hoover issued Executive Order 5398, creating an independent federal

⁴ (...continued)

Benefits: Issues in the 110th Congress, by Carol D. Davis, Coordinator.

⁵ U.S. Congress. House. Committee on Veterans' Affairs, *The Provision of Federal Benefits for Veterans*, Committee print, 84th Congress, 1st session, December 28, 1955, House Committee Print No. 171. p.2.

⁶ For a detailed description of the evolution of eligibility for VA health care, see CRS Report RL32961, *Veterans' Health Care Issues in the 109th Congress*, by Sidath Viranga Panangala.

⁷ Lisa Dubay, John Holahan, and Allison Cook. "The Uninsured And The Affordability Of Health Insurance Coverage," *Health Affairs - Web Exclusive*, November 30, 2006. Catherine Arnst, "The Best Medical Care in the U.S." *Business Week*, July 17, 2006 p.50.

agency known as the Veterans Administration by consolidating many separate veterans' programs.⁸ On October 25, 1988, President Reagan signed legislation (P.L. 100-527) creating a new federal cabinet-level Department of Veterans Affairs to replace the Veterans Administration, effective March 15, 1989. VA carries out its veterans' programs nationwide through three administrations and the Board of Veterans Appeals (BVA). The Veterans Health Administration (VHA) is responsible for veterans' health care programs. The Veterans Benefits Administration (VBA) is responsible for compensation, pension, vocational rehabilitation, education assistance, home loan guaranty and insurance among other things. The National Cemetery Administration's (NCA) responsibilities include maintaining 120 national cemeteries in 39 states and Puerto Rico. The Board of Veterans Appeals (BVA) renders final decisions on appeals on veteran benefits claims.⁹

Veterans' Health Care System

VHA operates the nation's largest integrated direct health care delivery system.¹⁰ VA's health care system is organized into 21 geographically defined Veterans Integrated Service Networks (VISNs) (see **Figure 1**). While policies and guidelines are developed at VA headquarters and applied throughout the VA health care system, management authority for basic decision making and budgetary responsibilities are delegated to the VISNs.¹¹ Congressionally appropriated medical care funds are allocated to the VISNs based on the Veterans Equitable Resource Allocation (VERA) system, which generally bases funding on patient workload.¹² Prior to the implementation of the VERA system, resources were allocated to facilities primarily on the basis of their historical expenditures. Unlike Medicare, which administers medical care through the private sector, the VA provides care directly to veterans.

In FY2007, VHA operated 155 medical centers, 135 nursing homes, 717 ambulatory care and community-based outpatient clinics (CBOCs),¹³ 45 residential

⁸ In the 1920s three federal agencies, the Veterans Bureau, the Bureau of Pension in the Department of the Interior, and the National Home for Disabled Volunteer Soldiers, administered various benefits for the nation's veterans.

⁹ For details on the appeals process, see CRS Report RL33704, *Veterans Affairs: The Appeal Process for Veterans' Claims*, by Douglas Reid Weimer.

¹⁰ Established on January 3, 1946, as the Department of Medicine and Surgery by P.L. 79-293, succeeded in 1989 by the Veterans Health Services and Research Administration, renamed the Veterans Health Administration in 1991.

¹¹ Jian Gao, Ying Wang and Joseph Engelhardt, "Logistic Analysis of Veterans' Eligibility-Status Change," *Health Services Management Research*, vol. 18, (August 2005), p. 175.

¹² About 90% of the VHA appropriation is allocated through VERA. Networks also receive appropriated funds not allocated through VERA for such things as prosthetics, homeless programs, readjustment counseling, and clinical training programs. VA facilities could also retain collections from insurance reimbursements and copayments, and use these funds for the care of veterans.

¹³ On June 23, 2006, VA announced plans to open 25 new CBOCs in 17 states and American Samoa. The following facilities were scheduled to become operational in CY2006: (continued...)

rehabilitation treatment programs, and 209 Vet Centers (generally these are community-based, non-medical facilities that offer counseling services).¹⁴ VHA also pays for care provided to veterans by independent providers and practitioners on a fee basis under certain circumstances. Inpatient and outpatient care is provided in the private sector to eligible dependents of veterans under the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA).¹⁵ In addition, VHA provides grants for construction of state-owned nursing homes and domiciliary facilities, and collaborates with the Department of Defense (DOD) in sharing health care resources and services. Today, VHA has been commended by peer reviewed journals and independent studies as an outstanding health care system whose “performance now surpasses that of other health systems on standardized quality measures.”¹⁶ The journal *Neurology* in its November 2006 issue noted that “The VA has achieved remarkable improvements in patient care and health outcomes, and is a cost-effective and efficient organization. Its enrollees are provided comprehensive coverage ... and the system is especially suited to manage chronic disease.”¹⁷ In 2005, *Health Care Papers* dedicated a complete issue to examining the transformation of VHA, and the lessons that could be learned by other countries struggling to use their healthcare resources appropriately.¹⁸ Furthermore, VA has led private-sector health care in the American Customer Satisfaction Index for both inpatient and outpatient services.¹⁹

Veterans Health Information Systems and Technology Architecture (VistA). The previously discussed achievements are related in part to the VHA’s development and use of electronic health records. Since 1985, VHA has had an automated information system with extensive clinical and administrative capabilities

¹³ (...continued)

Bessemer, Alabama; Tafuna, American Samoa; Miami-Globe, Northwest Tucson and Southeast Tucson, Arizona; South Orange County, California; Dover, Delaware; Athens, Georgia; Canyon County, Idaho; Spirit Lake, Iowa; Hazard and Florence, Kentucky; Bemidji, Minnesota; Holdrege, Nebraska; Fallon, Nevada; Franklin, Hamlet, and Hickory, North Carolina; Cambridge and Newark, Ohio; Hamblen, Tennessee; Conroe, Texas; Lynchburg and Norfolk, Virginia; Rice Lake, Wisconsin.

¹⁴ Data from the *FY2008 Congressional Budget Submissions*, vol. 4 of 4. Number of facilities include facilities damaged by Hurricane Katrina. Data on the number of CBOCs differ from source to source. Some studies count clinics located at VA hospitals while others count only freestanding CBOCs. The number represented in this report excludes clinics located in VA hospitals. The data are current as of September 29, 2006.

¹⁵ For further information on CHAMPVA, see CRS Report RS22483, *Health Care for Dependents and Survivors of Veterans*, by Jacqueline Rae Roche and Sidath Viranga Panangala.

¹⁶ Kupersmith, Joel, et al. “Advancing Evidence-Based Care For Diabetes: Lessons From The Veterans Health Administration,” *Health Affairs* 26, no. 2 (2007): w156-w168 (published online January 26, 2007).

¹⁷ Feasby, Thomas E., “Is the Canadian health care system better for neurologic care?” *Neurology*, 2006; 67: 1744-1747.

¹⁸ Veterans Health Administration, *HealthcarePapers* vol. 5 no. 4, 2005.

¹⁹ See [<http://www.theacsi.org/>], accessed January 23, 2007.

which supports ambulatory, inpatient, and long-term care. VistA is the single, integrated health information system used throughout VA in all health care settings. VistA applications are comprised of three types of packages: the clinical package, the administration and financial package, and the infrastructure package. The clinical package includes applications such as the Computerized Patient Record System (CPRS). In addition to CPRS, VistA includes VistA Imaging and Bar-Code Medication Administration.

The CPRS is a single integrated system for VA health care providers. All aspects of a patient's medical record are integrated, including active problems, allergies, current medications, laboratory results, vital signs, hospitalizations and outpatient clinic history, alerts of abnormal results, among other things. It is used in about 1,300 VHA facilities around the country. CPRS also incorporates data from scheduling, laboratory, radiology, consults and clinic notes into a single integrated patient record.²⁰ Remote data view allows clinicians to see health data from any other VA facility where the veteran has received care. Also as a complement to CPRS, VistA includes VistA Imaging. This application provides a multimedia, online patient record that integrates traditional medical chart information with medical images including X-rays, pathology slides, video views, scanned documents, and cardiology exam results, among other images.

The Bar Code Medication Administration (BCMA) is an application that validates the administration of medications, including intravenous medications, in real time for inpatients in all VA medical centers. This ensures that the patient receives the correct medication, at the correct dosage and at the right time. BCMA also provides visual alerts. For instance, if the software detects a potential medical error, it alerts the nurse administering the medication. These alerts require the nurse to review and correct the reason for the alert before actually administering the drug to the patient. The overall cost of maintaining the VistA system is \$87 per patient annually.²¹

In 2006, Harvard University's Kennedy School of Government awarded the VA the Innovations in American Government Award for its electronic health records system. In presenting this award the Kennedy School stated that

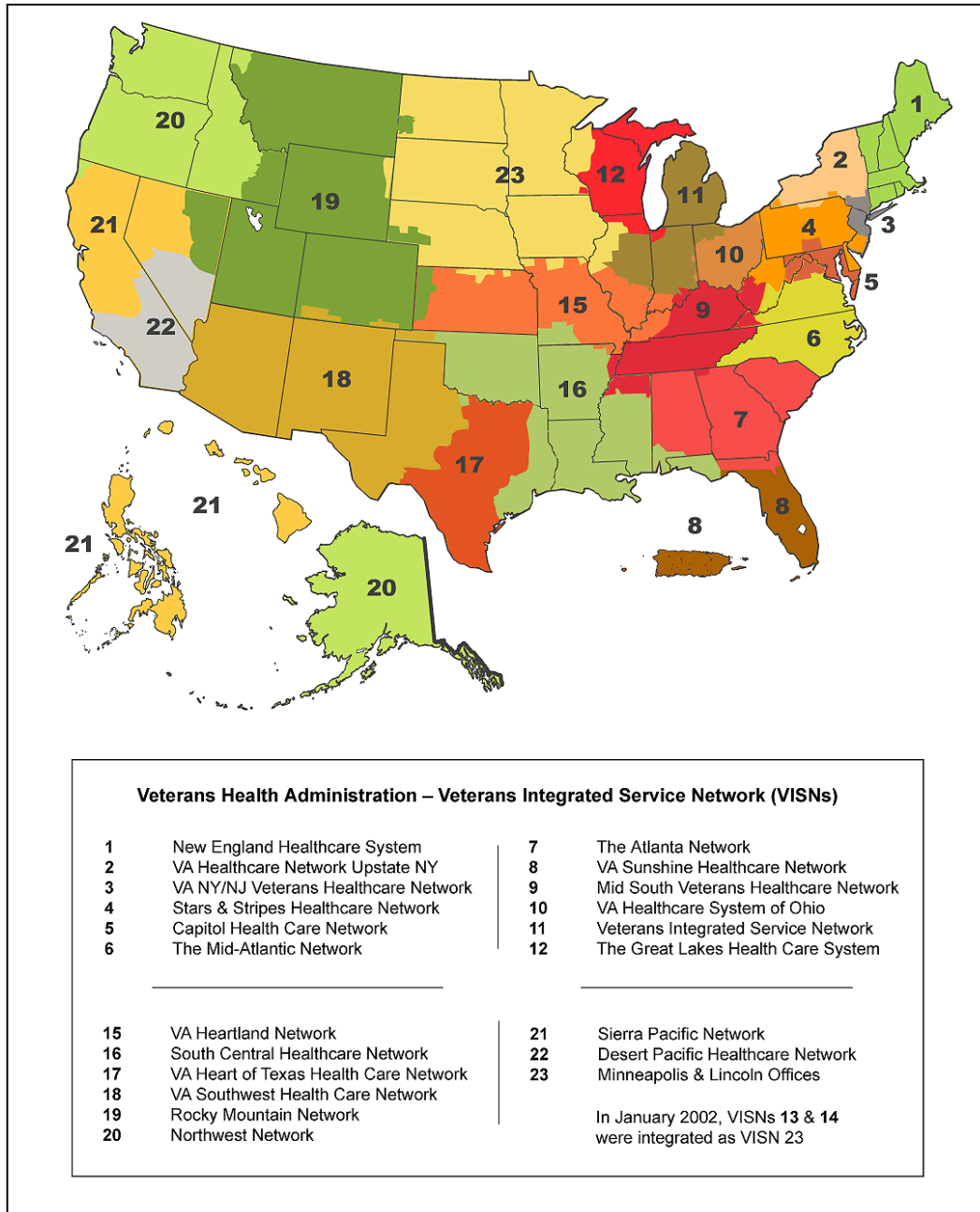
VistA saves lives and ensures continuity of care even under the most extreme circumstances. Many of the thousands of residents who fled the Gulf Coast because of Hurricane Katrina left behind vital health records. Records for the 40,000 veterans in the area were almost immediately available to clinicians across the country, even though the VA Medical Center in Gulfport, Mississippi, was destroyed and New Orleans VA Medical Center was closed and evacuated. Veterans were able to resume their treatments, refill their prescriptions, and get

²⁰ Nedal Arar, Lonnie Wen, John McGrath, et al., "Communicating About Medications During Primary Care Outpatient Visits: The Role of Electronic Medical Records," *Informatics in Primary Care*, vol. 13, p. 14.

²¹ Caron Golden, "VA's Model of Success," *Government Leader*, November/December, 2006, p. 27.

the care they needed because their medical records were immediately accessible to providers at other VA facilities.²²

Figure 1. Veterans Integrated Services Networks (VISNs)



Source: Information provided by the Department of Veterans Affairs. Map Resources. Adapted by CRS.

Note: VISN 21, the Sierra Pacific Network, includes northern and central California, northern Nevada, Hawaii, the Philippines, and several Pacific islands including Guam and American Samoa.

²² See [<http://www.excelgov.org/UserFiles/VA%20VistA%20release%20finale.pdf>].

Veteran Population

At the end of FY2006 the veterans population in the United States was approximately 24 million, and of these 17.8 million were war veterans. According to the VA, the total veteran population is expected to decline to 21.7 million by 2011, and 18.1 million by 2020. VA attributes this decline to the number of veteran deaths exceeding the number of new separations from the military.²³ The largest population of veterans are living in California, followed by Florida and Texas (**Figure 2**). In FY2005 there were approximately 7.7 million veterans enrolled in the VA health care system (**Figure 3**). Most VISNs showed enrollments between 26%-30% of the total eligible veteran population in those VISNs; two VISNs (VISN 5 and VISN 11) showed enrollments below 25%. The total number of veterans enrolled in VA's health care system is estimated to increase to almost 8.0 million veterans in FY2008. It should be noted that in any given year not all veterans seek care from VA, either because they are not ill or because they have other sources of care such as private health insurance.

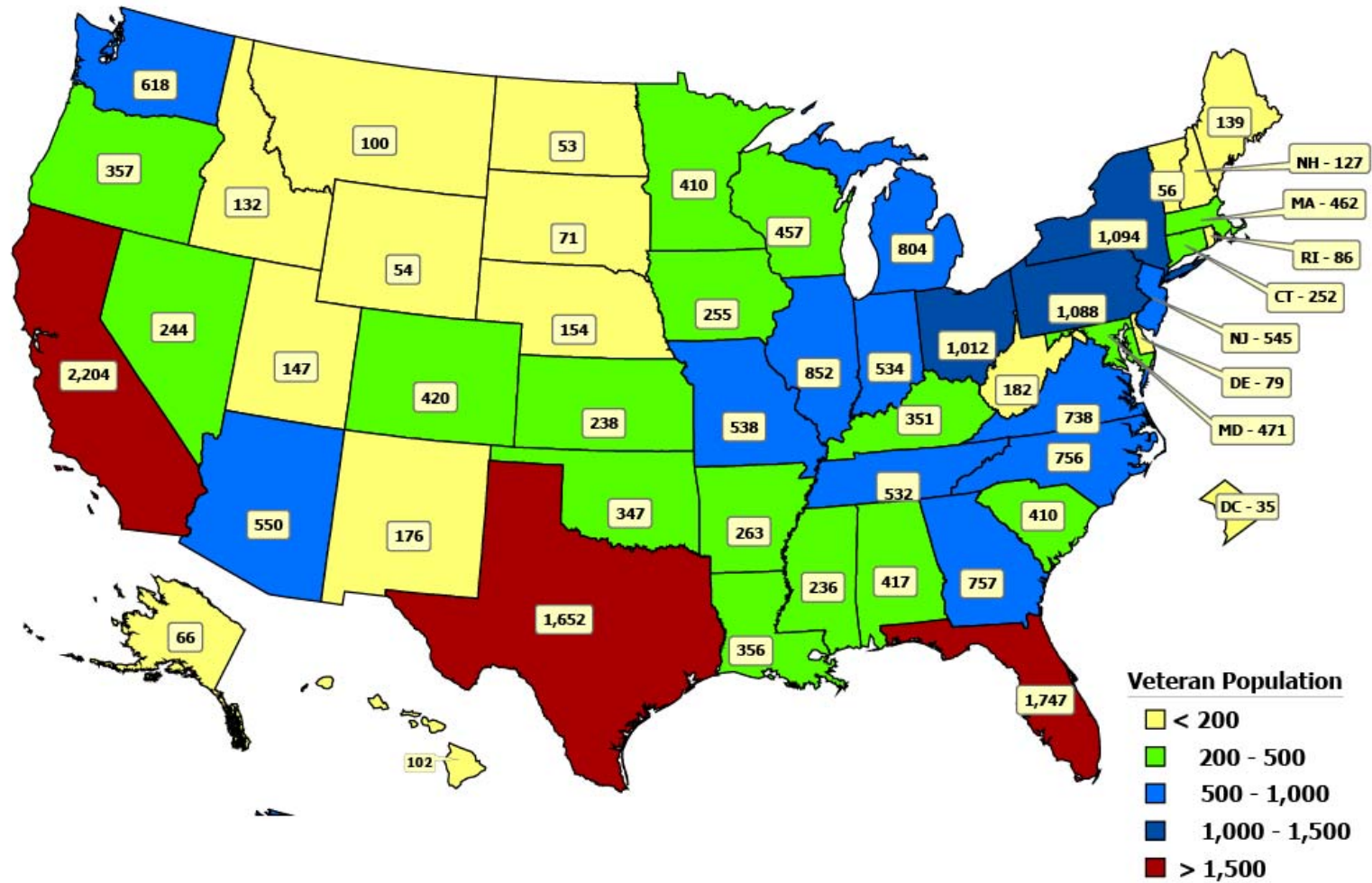
In FY2005, VHA provided care to approximately 4.9 million unique patients. The greatest number of patients were in VISNs 4, 8 and 16. Each of these VISNs had more than 265,000 patients (**Figure 4**). The overall patient population reflects where the total veteran population is the largest. During FY2007, VHA provided health care to about 5.2 million unique veteran patients. These patients generated 64.4 million outpatient visits and almost 800,000 inpatient episodes of care.²⁴ According to VHA estimates, the number of unique veteran patients is estimated to increase by approximately 109,000 between FY2007 and FY2008.²⁵ And VA is expected to treat about 5.3 million veteran patients in FY2008. Patients in Priority Groups 1-6 (described below) — those veterans with service-connected conditions, lower incomes, special health care needs, and service in Iraq or Afghanistan — will comprise 75% of the total veteran patient population in FY2008.

²³ U.S. Department of Veterans Affairs, Office of the Secretary, *Strategic Plan FY2006-2011*, October 2006, p.11.

²⁴ VHA schedules about 39 million appointments a year. According to VHA, 37 million of these are scheduled within 30 days of the request of the patient's desired date.

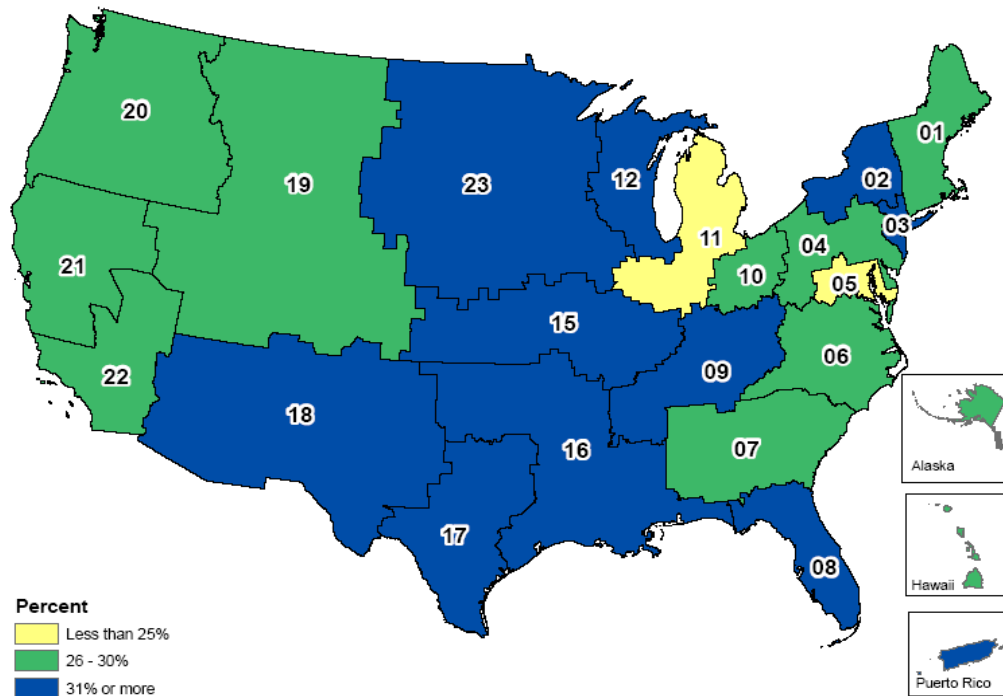
²⁵ U.S. Department of Veterans Affairs, *FY2008 Congressional Budget Submissions, Medical Programs*, vol. 1 of 4, p.2-2.

Figure 2. Veteran Population by State as of September 30, 2006 (in thousands)



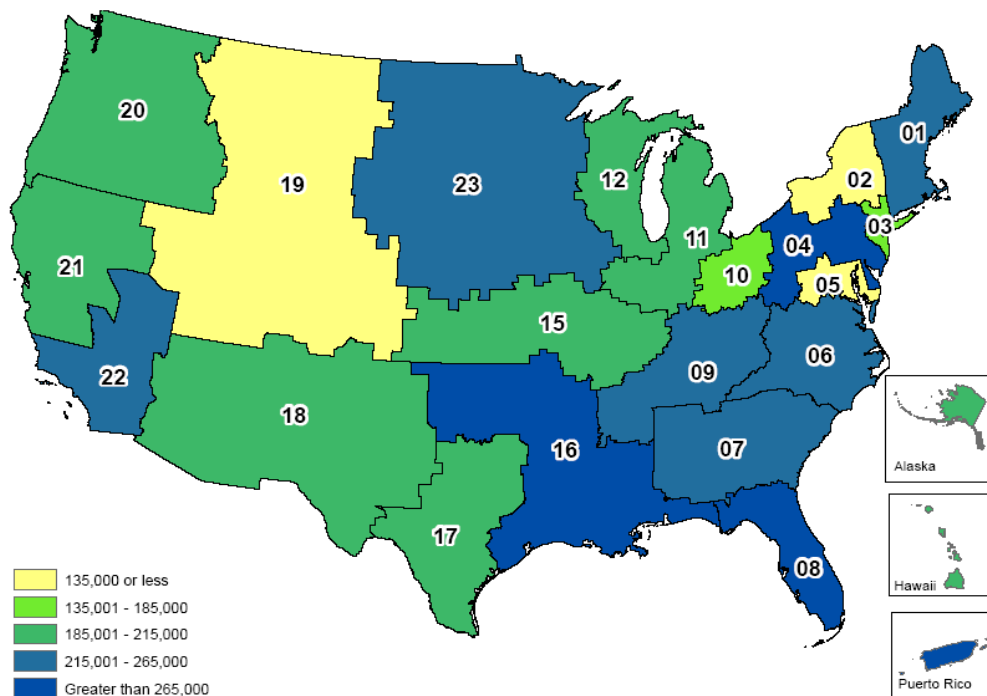
Source: Department of Veterans Affairs.

Figure 3. Percent of Veterans Enrolled in the VA Health Care System by VISN, FY2005



Source: Department of Veterans Affairs.

Figure 4. Number of Patients by VISN, FY2005



Source: Department of Veterans Affairs.

Eligibility for Veterans' Health Care

“Promise of Free Health Care”

To understand some of the issues discussed later in this report, it is important to understand eligibility for VA health care, VA's enrollment process, and its enrollment priority groups. Unlike Medicare or Medicaid, VA health care is not an entitlement program. Contrary to numerous claims made concerning “promises” to military personnel and veterans with regard to “free health care for life,” not every veteran is automatically entitled to medical care from VA.²⁶ Prior to eligibility reform in 1996, all veterans were technically eligible for some care, however, the actual provision of care was based on available resources.²⁷

The Veterans' Health Care Eligibility Reform Act of 1996, P.L. 104-262, established two eligibility categories and required VHA to manage the provision of hospital care and medical services through an enrollment system based on a system of priorities.²⁸ P.L. 104-262 authorized VA to provide all needed hospital care and medical services to veterans with service-connected disabilities, former prisoners of war, veterans exposed to toxic substances and environmental hazards such as Agent Orange, veterans whose attributable income and net worth are not greater than an established “means test,” and veterans of World War I. These veterans are generally known as “higher priority” or “core” veterans.²⁹ The other category of veterans are those with no service-connected disabilities and with attributable incomes above an established “means test.”

P.L. 104-262 also authorized VA to establish a patient enrollment system to manage access to VA health care. As stated in the report language accompanying P.L. 104-262,

[t]he Act would direct the Secretary, in providing for the care of ‘core’ veterans, to establish and operate a system of annual patient enrollment and require that veterans be enrolled in a manner giving relative degrees of preference in accordance with specified priorities. At the same time, it would vest discretion in the Secretary to determine the manner in which such enrollment system would operate.³⁰

²⁶ For a detailed discussion of “promised benefits,” see CRS Report 98-1006, *Military Health Care: The Issue of “Promised” Benefits*, by David F. Burrelli.

²⁷ Barbara Sydell, *Restructuring the VA Health Care System: Safety Net, Training and Other Considerations*, National Health Policy Forum, Issue Brief no. 716, March 1998. Available at [http://www.nhpf.org/pdfs_ib/IB716_VA_3-25-98.pdf].

²⁸ U.S. Congress, House Committee on Veterans Affairs, *Veterans' Health Care Eligibility Reform Act of 1996*, report to accompany H.R. 3118, 104th Cong. 2nd sess., H.Rept. 104-690, p. 2.

²⁹ Ibid. p.5.

³⁰ Ibid. p.6.

Furthermore, P.L. 104-262 was clear in its intent that the provision of health care to veterans was dependent upon the available resources. The Committee report accompanying P.L. 104-262 states that the provision of hospital care and medical services would be provided to “the extent and in the amount provided in advance in appropriations Acts for these purposes. Such language is intended to clarify that these services would continue to depend upon discretionary appropriations.”³¹

VHA Health Care Enrollment

As stated previously, P.L. 104-262 required the establishment of a national enrollment system to manage the delivery of inpatient and outpatient medical care. The new eligibility standard was created by Congress to “ensure that medical judgment rather than legal criteria will determine when care will be provided and the level at which care will be furnished.”³²

For most veterans, entry into the veterans’ health care system begins by completing the application for enrollment. Some veterans are exempt from the enrollment requirement if they meet special eligibility requirements.³³ A veteran may apply for enrollment by completing the Application for Health Benefits (VA Form 10-10EZ) at any time during the year and submitting the form online or in person at any VA medical center or clinic, or mailing or faxing the completed form to the medical center or clinic of the veteran’s choosing.³⁴ See **Table 1** for steps in the enrollment process.

³¹ Ibid. p.5.

³² Ibid. p.4.

³³ Veterans do not need to apply for enrollment in VA’s health care system if they fall into one of the following categories: veterans with a service-connected disability rated 50% or more (percentage ratings represent the average impairment in earning capacity resulting from diseases and injuries encountered as a result of or incident to military service; those with a rating of 50% or more are placed in Priority Group 1); less than one year has passed since the veteran was discharged from military service for a disability that the military determined was incurred or aggravated in the line of duty, but the VA has not yet rated; or the veteran is seeking care from VA for only a service-connected disability (even if the rating is only 10%).

³⁴ VA Form 10-10EZ is available at [<https://www.1010ez.med.va.gov/sec/vha/1010ez/#Process>].

Table 1. Health Enrollment Process

Step 1	The veteran may apply for enrollment in person at a VA health care facility, by mail, or by completing an on-line application. VHA uses the military service, demographic and, as applicable, financial information collected on the application form as the basis for determining whether the veteran qualifies for VA health care benefits.
Step 2	The local VA health care facility receives the application for enrollment and intake staff enter the data into the Veterans Health Information Systems and Technology Architecture (VistA). VistA automatically queries the Master Patient Index (MPI) to determine if a record has already been established, if not it uniquely identifies the veteran record. At this time, the intake staff may also query VBA for compensation and pension and/or known military status information. Typically, the veteran is provided a preliminary eligibility determination at the conclusion of an in-person application for enrollment.
Step 3	VistA transmits the veteran data to the Eligibility and Enrollment System (national system).
Step 4	The Eligibility and Enrollment System establishes the veteran's record and queries the Social Security Administration (SSA) to verify the veteran's Social Security Number (SSN). Note: SSN verification does not occur in real time and is not on the critical path.
Step 5	The Enrollment System queries VBA to reconfirm the compensation and pension and/or military status. Currently, this is done in a batch mode; however, when VHA deploys Enrollment System Redesign (ESR), the Enrollment System will immediately trigger a query to VBA; as a result the cycle time, for the enrollment process noted above will be reduced by another day.
Step 6	The Enrollment System verifies the veteran's enrollment eligibility and shares this data with VistA (at the local level). Note: If the Enrollment System is unable to verify eligibility, then the system sends the local VA Medical Center a bulletin to alert them to take further action (i.e., confirm whether the veteran has qualifying military service). The Enrollment System establishes an enrollment record upon transmission of verifying data by the local station.
Step 7	The Enrollment System produces the letter to the veteran with the official enrollment determination.
Step 8	The veteran receives the letter from VA telling him or her about their eligibility and enrollment determination.

Source: Appendix C. *Task Force on Returning Global War on Terror Heroes* report, Department of Veterans Affairs.

Once a veteran is enrolled in the VA health care system the veteran remains in the system and does not have to re-apply for enrollment annually. However, those veterans who have been enrolled in Priority Group 5 based on income must submit a new VA Form 10-10EZ annually with updated financial information demonstrating inability to defray the expenses of necessary care.³⁵

Veteran's Status. Eligibility for VA health care is primarily based on “veteran’s status” resulting from military service. Veteran’s status is established by active-duty status in the military, naval, or air service and an honorable discharge or release from active military service. Generally, persons enlisting in one of the armed forces after September 7, 1980, and officers commissioned after October 16, 1981, must have completed two years of active duty or the full period of their initial service obligation to be eligible for VA health care benefits. Servicemembers discharged at any time because of service-connected disabilities are not held to this requirement. Also, reservists that were called to active duty and who completed the term for which they were called, and who were granted an other than dishonorable discharge are exempt from the 24 continuous months of active duty requirement. National Guard members who were called to active duty by federal executive order are also exempt from this two year requirement if: 1) they completed the term for which they were called, and 2) were granted an other than dishonorable discharge.

When not activated to full-time federal service, members of the reserve components and National Guard have limited eligibility for VA health care services. Members of the reserve components may be granted service-connection for any injury they incurred or aggravated in the line of duty while attending inactive duty training assemblies, annual training, active duty for training, or while going directly to or returning directly from such duty. Additionally, reserve component servicemembers may be granted service-connection for a heart attack or stroke if such an event occurs during these same periods. The granting of service-connection makes them eligible to receive care from VA for those conditions. National Guard members are not granted service-connection for any injury, heart attack, or stroke that occurs while performing duty ordered by a governor for state emergencies or activities.³⁶

Priority Groups. After veteran’s status has been established, VA next places applicants into one of two categories. The first group is composed of veterans with service-connected disabilities or with incomes below an established means test. These veterans are regarded by VA as “high priority” veterans, and they are enrolled in Priority Groups 1-6 (see **Appendix 1**). Veterans enrolled in Priority Groups 1-6 include:

- veterans in need of care for a service-connected disability;³⁷

³⁵ 38 C.F.R. §17.36 (d)(3)(iv) (2005).

³⁶ 38.U.S.C. §101(24); 38 C.F.R. §3.6(c).

³⁷ The term “service-connected” means, with respect to disability, that such disability was incurred or aggravated in line of duty in the active military, naval, or air service. VA determines whether veterans have service-connected disabilities, and for those with such

(continued...)

- veterans who have a compensable service-connected condition;
- veterans whose discharge or release from active military, naval or air service was for a compensable disability that was incurred or aggravated in the line of duty;
- veterans who are former prisoners of war (POWs);
- veterans awarded the purple heart;
- veterans who have been determined by VA to be catastrophically disabled (these are veterans who have a permanent severely disabling injury, disorder, or disease that compromises the ability to carry out the activities of daily living);
- veterans of World War I;
- veterans who were exposed to hazardous agents (such as Agent Orange in Vietnam) while on active duty; and
- veterans who have an annual income and net worth below a VA-established means test threshold.

VA also looks at applicants' income and net worth to determine their specific priority category and whether they have to pay copayments for nonservice-connected care. In addition, veterans are asked to provide VA with information on any health insurance coverage they have, including coverage through employment or through a spouse. VA may bill these payers for treatment of conditions that are not a result of injuries or illnesses incurred or aggravated during military service.

The second group is composed of veterans who do not fall into one of the first six priority groups. These veterans are primarily those with nonservice-connected medical conditions and with incomes and net worth above the VA established means test threshold. These veterans are enrolled in Priority Group 7 or 8 (see **Appendix 1**).³⁸

Health Services

VHA provides a standard benefits package to all enrolled veterans. Broadly, this includes preventive care services (e.g., immunizations, physical examinations, health care assessments, screening tests); inpatient and outpatient medical care, surgery, and mental health care, including care for substance abuse; prescription drugs, including over-the-counter drugs and medical and surgical supplies; and durable medical equipment and prosthetic and orthotic devices, including eyeglasses and hearing aids.

³⁷ (...continued)

disabilities, assigns ratings from 0 to 100% based on the severity of the disability. Percentages are assigned in increments of 10%.

³⁸ VA considers a veteran's previous year's total household income (both earned and unearned income as well as his/her spouse's and dependent children's income). Earned income is usually wages received from working. Unearned income can be interest earned, dividends received, money from retirement funds, Social Security payments, annuities, or earnings from other assets. The number of persons in the veteran's family will be factored into the calculation to determine the applicable income threshold. 38 C.F.R. § 17.36(b)(7) (2005).

Medical Care for Returning Injured Servicemembers

Overview

The *National Strategy for Combating Terrorism* issued in September 2006, stated that the “War on Terror will be a long war.”³⁹ Along with all other facets of the U.S. government, it is likely that the U.S. military will continue to play a leading role in this “long war.” Since the terrorist attacks of September 11, 2001, U.S. Armed Forces have been deployed in two major theaters of operation. Operation Enduring Freedom (OEF) in Afghanistan and Operation Iraqi Freedom (OIF) constitute the largest sustained ground combat mission undertaken by the United States since the Vietnam War. Veterans from these conflicts and from previous wars are exerting tremendous stress on the VA health care system. With increased patient workload and rising health care costs, the 110th Congress is focused on ensuring a “seamless transition” process for veterans moving from active duty into the VA health care system.

Compared with previous wars that the nation has fought, because of the advancement in battle field medicine, a larger proportion of soldiers are surviving their injuries. In World War II, 30% of the U.S. servicemembers injured in combat died. In Vietnam, the proportion dropped to 24%. In OEF and OIF operations about 10% of those injured have died.⁴⁰ In November 2007, DOD reported that over 30,000 servicemembers have been wounded in action since the beginning of OEF and OIF.⁴¹ With increasing numbers of soldiers returning from Iraq and Afghanistan — both injured and non-injured — Congress and veterans’ advocates are very concerned that returning servicemembers may not have a smooth transition from DOD health care to VA health care. The final report of the President’s Commission on Care for America’s Returning Wounded Warriors acknowledged that handoffs between inpatient and outpatient care and between the two separate DOD and VA health care and disability systems are problematic.⁴² *It should be noted that injured servicemembers receiving care in VA health care facilities are not considered veterans until they are formally discharged from active duty service.*⁴³

³⁹ National Security Council, *National Strategy for Combating Terrorism*, September 2006, p.19, available at [<http://www.whitehouse.gov/nsc/nsct/2006/nsct2006.pdf>].

⁴⁰ Atul Gawande, “Casualties of War - Military Care for the Wounded from Iraq and Afghanistan,” *The New England Journal of Medicine*, vol.351, iss. 24, (December 2004), p. 2471.

⁴¹ Data current as of November 24, 2007 [<http://www.defenselink.mil/news/casualty.pdf>].

⁴² The President’s Commission on Care for America’s Returning Wounded Warriors, July 2007, p.2, available at [<http://www.pccww.gov>].

⁴³ Title 38 U.S.C. §§ 8111, Sharing of Department and Department of Defense Health Care Resources, provides the authority for VA and the DOD to enter into agreements and contracts for the mutual use or exchange of use of services, supplies or other resources. Title 38 U.S.C. §§ 8111A, Furnishing of Health-care Services to Members of the Armed Forces During a War or National Emergency, authorizes VA to provide care during and immediately following a period of war, or a period of national emergency as declared by the (continued...)

OEF and OIF Veterans

Since the onset of OEF and OIF, more than 1.6 million servicemembers have served in these two theaters of operation, making them potentially eligible for veterans benefits.⁴⁴ Since FY2002, 751,273 OEF and OIF veterans have separated (discharged) from active duty.⁴⁵ Of this amount, 362,237, or 48%, were active duty troops, while 389,036, or 52%, were separated National Guard and Reserve component members. Approximately 35%, or 263,909, of all separated OEF and OIF veterans since FY2002 have sought care from VA. About 96% of the veterans who sought care have received outpatient care, while 4%, or a little more than 10,000, have been hospitalized at least once in a VHA facility. **Figure 5** provides a breakdown of the five major diagnoses among returning OIF and OEF veterans. While diseases of the musculoskeletal system have the highest frequency of diagnosis, mental disorders ranks second among major diagnoses. Mental disorders may include, among other conditions, nondependent abuse of drugs, alcohol dependent syndrome, and PTSD.

Figure 6 below provides data on the number of OEF and OIF discharges per fiscal year. The number of new discharges was highest in FY2004, followed by FY2003, whereas FY2006 had the lowest number of discharges. However, note that the numbers in the graph are from FY2002-FY2006 and do not reflect the most recent data presented above, which includes FY2007 3rd quarter data.

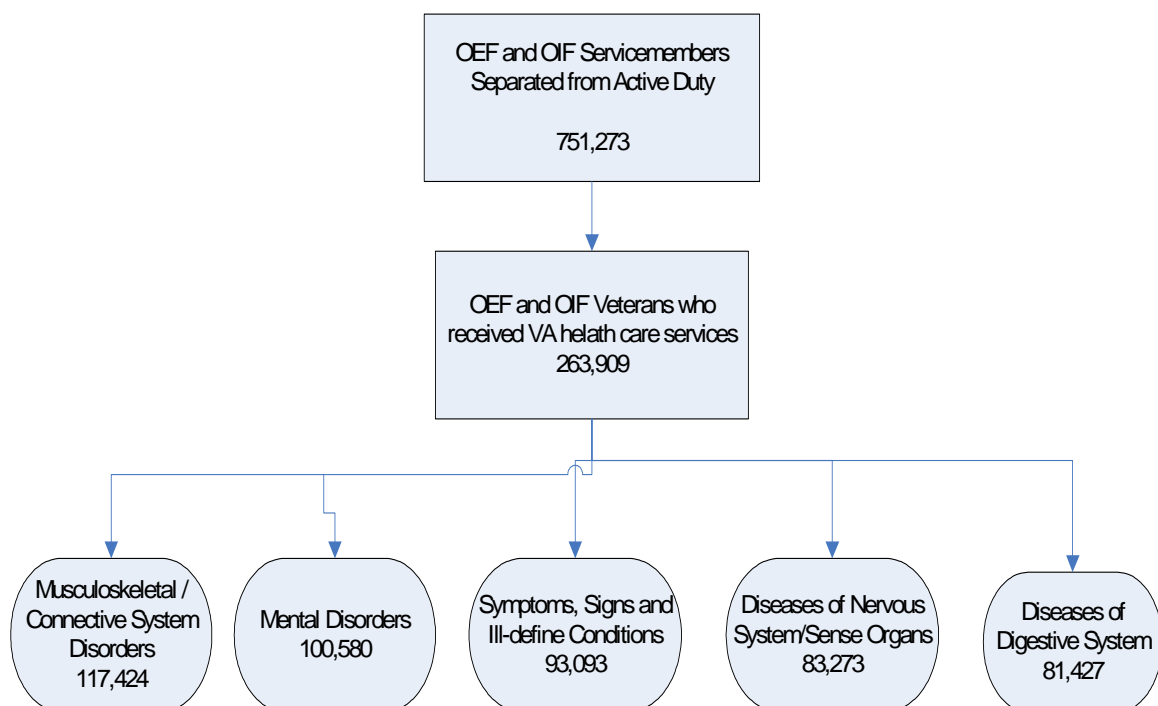
⁴³ (...continued)

President or Congress that involves the use of the Armed Forces in armed conflict. P.L. 97-174, Section 2(b), notes that DOD might not have adequate health care resources to care for military personnel wounded in combat and other active duty personnel. The law further notes that VA has an extensive, comprehensive health care system that could be used to assist DOD in caring for such personnel.

⁴⁴ OEF, which commenced in October 2001, conducts combat operations in Afghanistan and other locations. OIF, which began in March 2003, conducts combat operations in Iraq and other locations.

⁴⁵ Since October 2003, DOD's Defense Manpower Data Center (DMDC) has periodically (every 60 days) sent VA an updated personnel roster of troops who participated in OEF and OIF, and who have separated from active duty and become eligible for VA benefits. The roster was originally prepared based on pay records of individuals. However, in more recent months it has been based on a combination of pay records and operational records provided by each service branch. The current separation data are from FY2002 through May 31, 2007.

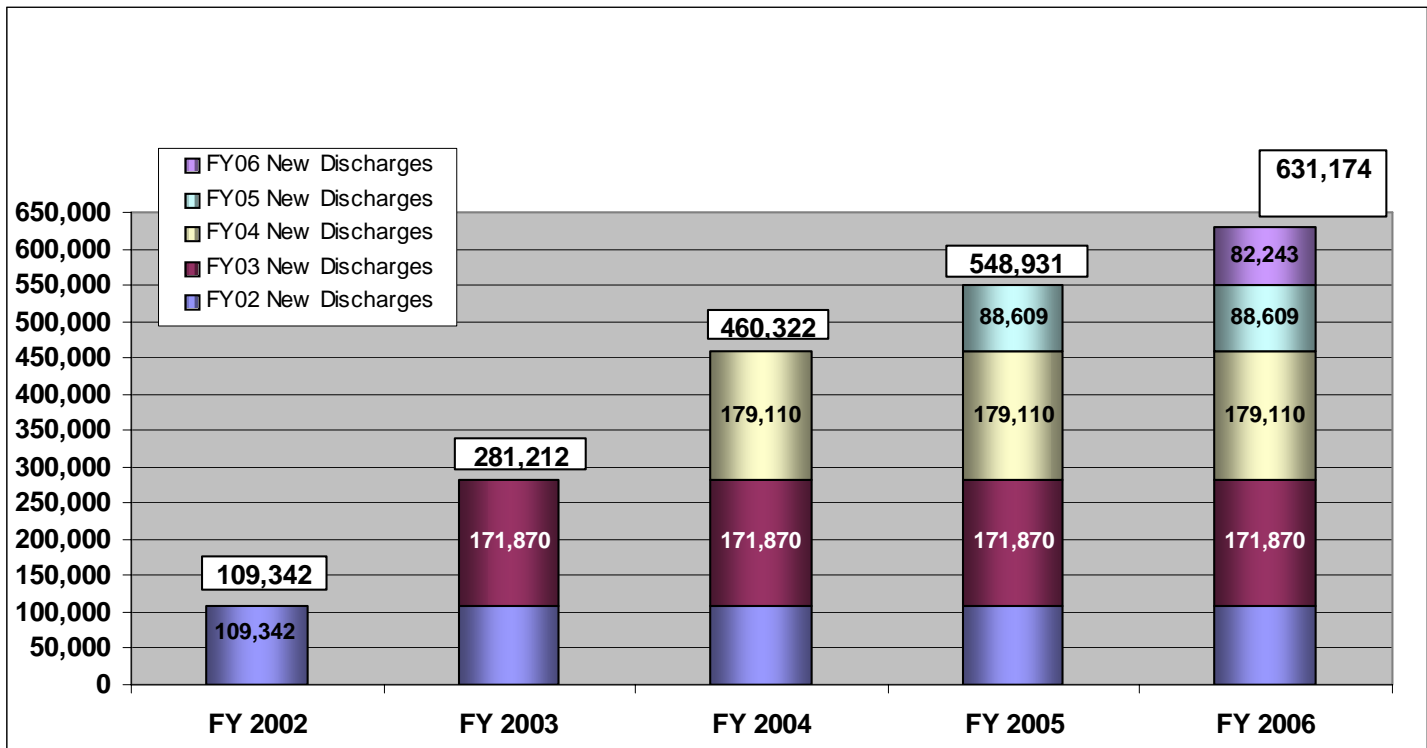
Figure 5. Frequency of Major Diagnoses among OEF and OIF Veterans



Notes: These diagnoses are based on broad International Classification of Diseases 9th Revision (ICD-9) categories. These data are cumulative data since FY2002, with data on hospitalizations and outpatient visits as of June 30, 2007. A veteran is counted only once in any single diagnostic category but can be counted in multiple categories. Therefore, above numbers add up to greater than 263,909.

Source: CRS Analysis of VA Data.

Figure 6. Cumulative Number of OIF and OIF Veterans Discharged from FY2002-FY2006

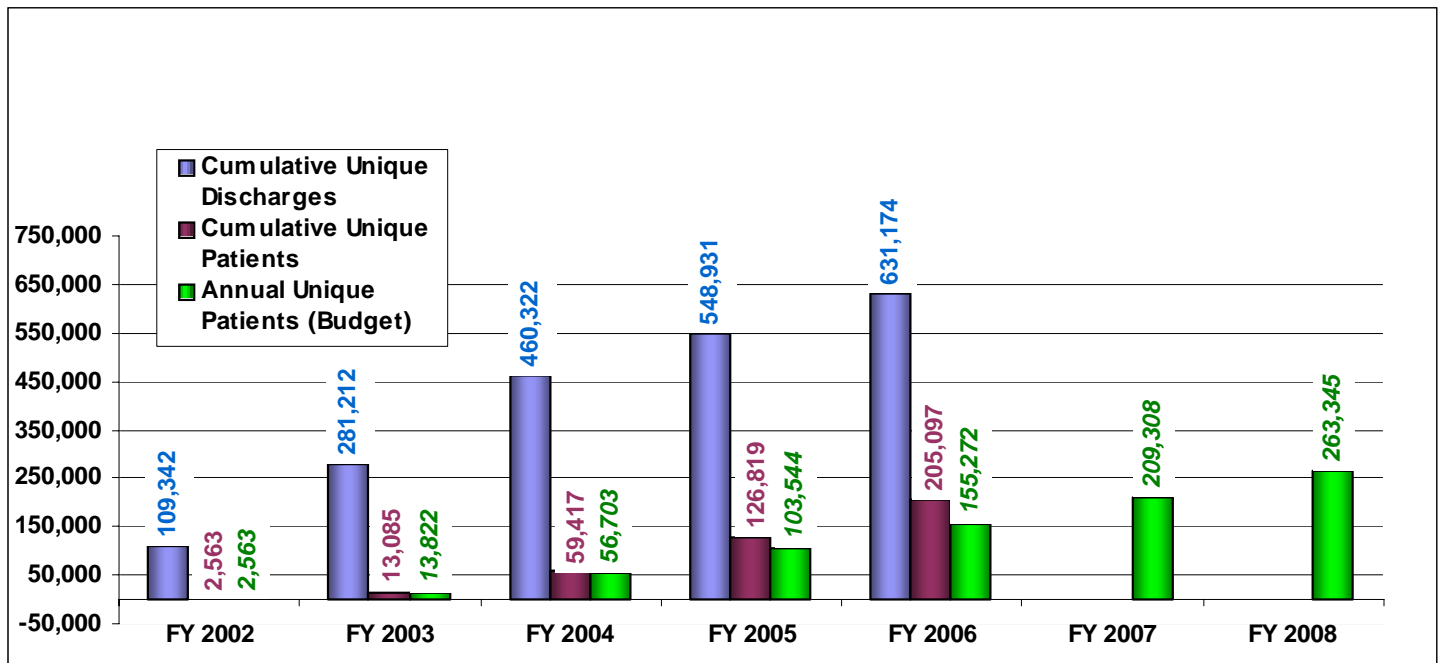


Source: Department of Veterans Affairs.

Although National Guard and Reserve component members make up 52% of OIF and OEF servicemembers who have separated from active duty, they compose 34% of those who have sought VA health care since FY2002. While active duty OIF and OEF servicemembers make up 48% of those who have separated from service, they make up 36% of those who have received VA care.

VA expects to treat 263,345 OEF and OIF veterans in FY2008 (**Table 2**). This is an increase of 54,037, or 26%, over the number of veterans from these two theaters of operation that VA anticipates will enter the VA health care system in FY2007, and 108,073, or 70%, more than the number VA treated in FY2006. As seen in **Table 2**, there is a 223% increase in funding between FY2005 and the projected amount for FY2008. **Figure 7** shows the cumulative number of unique OIF and OEF patients that the VA treated between FY2002 and FY2006, with projections for FY2007 and FY2008. In FY2005 and FY2006, VA treated more OIF and OEF veterans than it had budgeted for at the beginning of the fiscal year.

Figure 7. Cumulative Unique OIF and OEF Veteran Patients and OIF and OEF Discharges from FY2002 thru FY2006 Compared with Annual Number of Unique Patients



Source: Department of Veterans Affairs.

In March, VA testified that the number of severely injured or ill active duty servicemembers and veterans that have transitioned from DOD to VHA facilities is over 6,800;⁴⁶ of these 342 have been polytrauma patients.⁴⁷ VHA defines polytrauma as “injury to the brain in addition to other body parts or systems resulting in physical, cognitive, psychological, or psychosocial impairments and functional disability.”⁴⁸

As of April 1, there were 571 amputees reported by DOD. Since FY2002, VA’s Prosthetic and Sensory Aids Service (PSAS) has provided services and products to over 22,000 OEF and OIF unique veterans. PSAS has served a total of 187 major amputees (those with upper or lower limb amputations) from OEF and OIF, including veterans and active duty servicemembers.⁴⁹

⁴⁶ Testimony of Acting Under Secretary for Health Department of Veterans Affairs Dr. Michael J. Kussman, in U.S. Congress, House Committee on Veterans’ Affairs Subcommittee on Oversight and Investigations, hearing on *Servicemembers’ Seamless Transition into Civilian Life — The Heroes Return*, 110th Cong., 1st sess., March 8, 2007.

⁴⁷ Testimony of Acting Undersecretary for Health, Department of Veterans Affairs, Michael Kussman, in U.S. Congress, House Committee on Appropriations, Subcommittee on Military Construction, Veterans Affairs and Related Agencies, hearing on *FY 2008 funding for the Veterans Health Administration*, 110th Cong., 1st sess., March 6, 2007.

⁴⁸ Department of Veterans Affairs, Veterans Health Administration Directive. Polytrauma Rehabilitation Centers. Washington (DC): Veterans Health Administration; Jun 8, 2005, p. 2.

⁴⁹ Data provided by the Department of Veterans Affairs.

Table 2. VA Spending and Number of OIF and OEF Veteran Patients

	FY2005 actual	FY2006 actual	FY2007 estimate	FY2008 estimate
Obligations^a	\$232,500,000	\$404,840,000	\$572,562,000	\$752,438,000
Number of OEF/OIF patients	100,808	155,272	209,308	263,345
Average Annual Cost per OIF/OEF Patient	\$2,306	\$2,607	\$2,736	\$2,857

Source: U.S. Department of Veterans Affairs, *FY2008 Congressional Budget Submissions, Medical Programs*, vol. 1 of 4, pp. 9-14.

a. Total VA spending on OEF and OIF veteran patients.

Transition Issues

In 2003, several injured servicemembers or their parents testified on the obstacles faced during the transition from DOD's health care system to VHA.⁵⁰ However, since that time there have been significant improvements in that area as described later in this report. Aside from this day-to-day handoff, coordination and sharing of health information between VA and DOD has been problematic.⁵¹ In 2003, the President's Task Force to Improve Health Care Delivery for Our Nation's Veterans identified several issues with regard to sharing of information between DOD and VA. It stated that "the VA/DOD processes for sharing information about eligible service members do not facilitate quick and accurate enrollment into VA programs."⁵²

In March 2005, the Government Accountability Office (GAO) testified that VA still does not have systematic access to DOD data about returning servicemembers

⁵⁰ U.S. Congress, House Committee on Veterans' Affairs, Subcommittee on Health, *"Handoffs or Fumbles?" Are DOD and VA Providing Seamless Health Care Coverage to Transitioning Veterans?*, 108th Cong., 2nd sess., October 16, 2003.

⁵¹ For detailed information on issues related to disability evaluation of returning servicemembers see, CRS Report RL33991, *Disability Evaluation of Military Servicemembers* by Christine Scott, et al.

⁵² The President's Task Force to Improve Health Care Delivery for Our Nation's Veterans, Final Report, May 2003, p. 24.

who may need its services.⁵³ Again in September 2005, GAO testified that while VA has developed policies and procedures to provide OEF and OIF servicemembers and veterans with timely access to care, the sharing of health information between DOD and VA is limited.⁵⁴ In March 2007, GAO testified that despite coordination efforts by DOD and VA, these two Departments were still having problems sharing medical records.⁵⁵ Among other things, the recently appointed Task Force on Returning Global War on Terror Heroes identified that “currently, there are no formal interagency agreements between DOD and VA to transfer case management responsibilities across the military services and VA.”⁵⁶ In its July 2007 report, the President’s Commission on Care for America’s Returning Wounded Warriors acknowledged that handoffs between the two separate DOD and VA health care and disability systems have been problematic, and recommended the integration of medical and rehabilitation programming across the two Departments.⁵⁷

Initial Medical Care in DOD Facilities

In general, as shown in **Figure 8**, when a soldier is injured on the battlefield he or she is stabilized in theater by a combat medic/lifesaver and then moved to a battalion aid station. If the servicemember has serious injuries he or she is transferred to a forward surgical team to be stabilized and then moved to a combat support hospital and further stabilized for a period of about two days. If the servicemember needs more specialized care he or she is evacuated from OEF and OIF conflict theaters and brought to Landstuhl Regional Medical Center (LRMC) in Germany for treatment. Most patients arrive at LRMC 24 to 72 hours after injury. In general, servicemembers remain in Germany for a period of about 4 to five days.⁵⁸ Length of stay at in-theater medical facilities is determined by the stability of the patient and the availability of medical evacuation aircraft. After further stabilization at LRMC they are evacuated to the United States and arrive at an echelon V Military Treatment Facility (MTF) such as Walter Reed Army Medical Center (WRAMC) in Washington, DC, or the National Naval Medical Center in Bethesda, Maryland. All catastrophic burn patients are flown to the Brooke Army Medical Center (BAMC)

⁵³ U.S. Government Accountability Office, *VA Disability Benefits and Health Care, Providing Certain Services to the Seriously Injured Poses Challenges*, GAO-05-444T, p. 5.

⁵⁴ U.S. Government Accountability Office, *VA and DOD Health Care: VA Has Policies and Outreach Efforts to Smooth Transition from DOD Health Care, but Sharing of Health Information Remains Limited*, GAO-05-1052T.

⁵⁵ U.S. Government Accountability Office, *DOD and VA Health Care: Challenges Encountered by Injured Servicemembers during Their Recovery Process*, GAO-07-606T, p. 4.

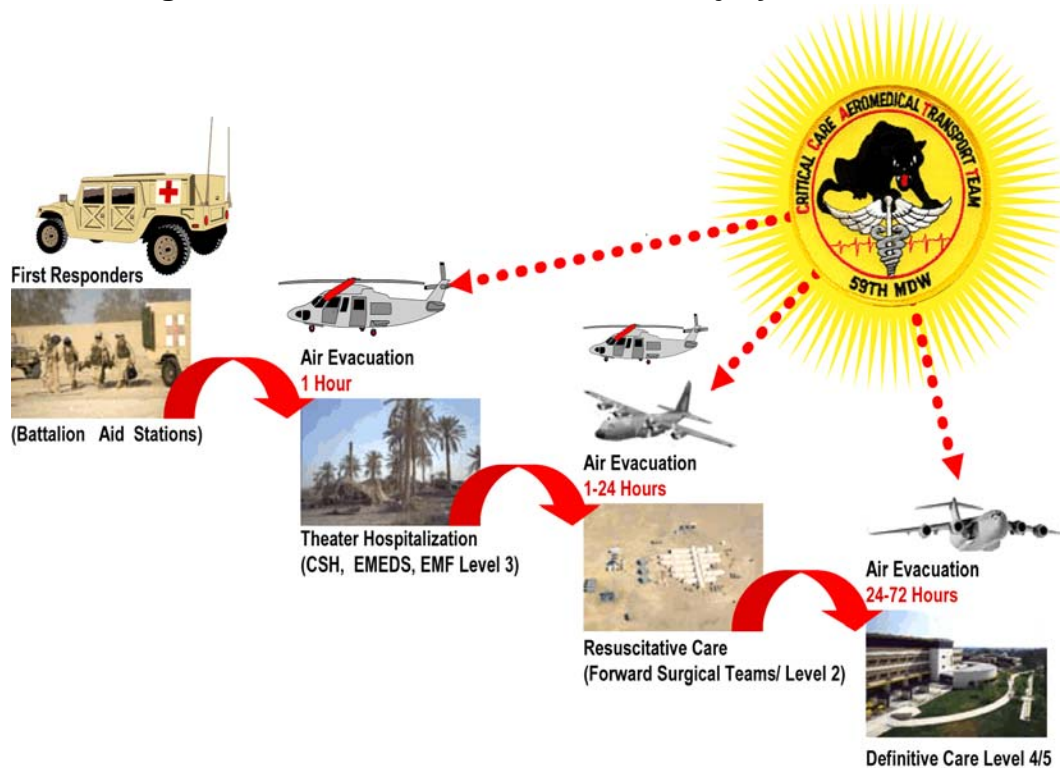
⁵⁶ *Task Force on Returning Global War on Terror Heroes*, Executive Summary, p.2.

⁵⁷ Report of the President’s Commission on Care for America’s Returning Wounded Warriors, July 2007, p.2 and 13, available at [<http://www.pccww.gov/>].

⁵⁸ Joachim J. Tenuta, “From the Battlefields to the States: The Road to Recovery. The Role of Landstuhl Regional Medical Center in US Military Casualty Care,” *Journal of the American Academy of Orthopedic Surgeons*, vol 14, (2006), S45-S47.

at Fort Sam Houston, Texas. BAMC has also established a specialized amputee rehabilitation center.⁵⁹

Figure 8. Current Level of Care from Injury to Definitive Care



Source: DOD, Major Alfred A. Hamilton, PH.D, Government Health IT 2007 Conference, Adapted by CRS Graphics.

Transfer and Care in VA Facilities

Once a seriously injured servicemember enters a major MTF, DOD can elect to send those with traumatic brain injuries (TBI) and other complex polytrauma cases to one of the four VA Polytrauma Rehabilitation Centers (PRCs) at the following locations: James A. Haley Veterans Affairs Medical Center (VAMC), Tampa, Florida; Minneapolis VAMC, Minneapolis, Minnesota; Veterans Affairs Palo Alto Health Care System, Palo Alto, California; and Hunter Holmes McGuire VAMC, Richmond, Virginia.⁶⁰ VA recently announced the decision to locate a fifth

⁵⁹ The Center for the Intrepid, a \$50 million, 60,000 sq. ft., physical rehabilitation center, and two new Fisher Houses, 21-room residences for hospitalized soldiers' families were declared open on January 29, 2007.

⁶⁰ The Veterans Health Programs Improvement Act of 2004 (P.L. 108-422) required VA to establish centers for research, education, and clinical activities related to complex trauma due to combat injuries, and the Department of Veterans Affairs, and Housing and Urban Development, and Independent Agencies Appropriations Act, 2005 (P.L. 108-447) required VA to establish a new prosthetics and integrative health care initiative. The PRCs were (continued...)

Polytrauma Center in San Antonio, Texas. As previously noted, injured servicemembers receiving care in VA health care facilities are not considered veterans until they are formally discharged from active duty service.

The PRCs have resources and clinical expertise to provide care for complex patterns of injuries, including TBI, traumatic or partial limb amputation, nerve damage, burns, wounds, fractures, vision and hearing loss, pain, mental health, and readjustment problems. In total there are currently 76 polytrauma clinic teams in the VA. These local teams of providers deliver follow up services in consultation with regional and network specialists. They also assist in management of stable patients through direct care, consultation and the use of tele-rehabilitation technologies, when needed. These PRCs have social work case managers at a ratio of one for every six patients. These case managers help assess the psychosocial needs of each patient and family, match treatment and support services to meet identified needs, coordinate services, and oversee the discharge planning process.⁶¹ **Table 3** provides an brief summary of VHA's polytrauma system of care.

⁶⁰ (...continued)

designated as a response to these mandates.

⁶¹ Statement of William F. Feeley, Deputy Undersecretary for Health for Operations and Management, Department of Veterans Affairs, hearing on *Servicemembers' Seamless Transition into Civilian Life — The Heroes Return*, in U.S. Congress, House Committee on Veterans Affairs, Subcommittee on Oversight and Investigations, 110th Cong., 1st sess., March 8, 2007.

Table 3. VHA's Polytrauma System of Care**Level I. Comprehensive Polytrauma Rehabilitation Centers (PRCs)**

- provide acute comprehensive medical, surgical, and rehabilitation care for complex and severe polytraumatic injuries
- serve as a resource to other facilities in the system via the development of tele-rehabilitation for consultation, best practices in polytrauma care, educational programs, and evaluation of new technology
- provide all clinical services and serve concurrently as Level II sites within their respective Veterans Integrated Service Networks (VISNs)

Level II. Polytrauma Network Sites (PNSs)

- there are 21 PNSs, one in each of VHA's 21 VISNs
- these sites manage veterans with complex injuries requiring specialized expertise as they return to their VISNs
- these sites provide a high level of expert care, with a full range of clinical and ancillary resources
- these sites provide specialized outpatient care to polytrauma patients not requiring inpatient services
- these sites develop a referral network within their VISN, and identify VISN resources for TBI/polytrauma services

Level III. Polytrauma Facility Teams (PFTs)

- these facilities have more limited resources than Level I and Level II centers
- Level III PFTs include a core polytrauma clinic team that could deliver a continuum of follow-up services in consultation with Level I and II centers
- these facilities are more likely to be closer to a veterans home and to provide day-to-day care, contact and support

Level IV. Polytrauma Care Coordination Points of Contact (POCs)

- these sites are smaller facilities with limited resources
- these sites serve as coordinators of referrals and consultations of polytrauma patients to Level I, II, or III facilities
- Level IV coordinators are knowledgeable about the services available within the system of care and about the avenues for access to care

Source: Department of Veterans Affairs, Office of Inspector General, *Health Status of and Services for Operation Enduring Freedom/Operation Iraqi Freedom Veterans after Traumatic Brain Injury Rehabilitation*, (Report No. 05-01818-165), July 12, 2006.

VA has stationed employees at Army and Navy hospitals to act as VHA/DOD liaisons.⁶² These VA/DOD liaisons assist with the transfer of patients as they move from MTFs to VHA hospitals and clinics. In general, once the MTF decides to transfer a patient to a PRC, it refers the patient to a VA/DOD liaison. The VA/DOD liaison then contacts the liaison at the PRC. The PRC completes a medical screening and initiates the transfer process. Medical records are obtained through direct access to WRAMC and Bethesda National Naval Medical Center. However, not all medical records are available electronically. In such cases Nursing Admissions Coordinators in PRCs obtain specific paper records through the VA/DOD liaison personnel stationed at both WRAMC and Bethesda. Video teleconferencing between the MTFs and PRCs provides an opportunity for families to meet the VA interdisciplinary team and facilitate the transition-of-care process.

Upon admission to a PRC, members of the rehabilitation team individually evaluate the servicemember within 24 hours.⁶³ According to the VA, the rehabilitation team generally meets three times weekly to discuss each patient and to continually adjust the therapeutic plan of care. "Each patient undergoes three to six hours of therapy each day based on their individual functional and cognitive needs."⁶⁴ By July 2007, VA plans to develop 4 Residential Transitional Rehabilitation Programs co-located with the Level I PRCs. The stated goal of these programs is to improve the veterans' physical, cognitive, communicative, behavioral, psychological and social functioning under necessary supervision, and to return these patients to active duty, work, school or independent living in the community.

In July 2007, the Dole-Shalala Commission proposed the appointment of recovery coordinators to manage individualized recovery plans that would be used to guide the servicemembers' care. The Dole-Shalala Commission further recommended that these recovery coordinators possibly come from the U.S. Public Health Service, and be highly skilled and have considerable authority to be able to access resources necessary to implement the recovery plans.⁶⁵ As reported recently

⁶² There are a total of ten VA/DOD liaisons located at Walter Reed Army Medical Center, Washington, DC (two VA/DOD liaisons); National Naval Medical Center, Bethesda, Maryland; Brooke Army Medical Center, Fort Sam Houston, Texas; Eisenhower Army Medical Center, Fort Gordon, Georgia; Fort Hood Army Medical Center, Fort Hood, Texas; Madigan Army Medical Center, Tacoma, Washington (two VA/DOD liaisons); Evans Army Medical Center Fort Carson, Colorado; Camp Pendleton, San Diego, California; Womack Army Medical Center, Ft. Bragg, North Carolina.

⁶³ The rehabilitation team consists of a Rehabilitation Physician, Rehabilitation Nurses, Physical Therapists, Occupational Therapists, Speech and Language Pathologists, Recreation Therapists, Kinesiotherapists, Neuropsychologists, Psychologists, Dieticians, Social Worker/Case Manager, Military Liaisons, and Blind Rehabilitation Therapists.

⁶⁴ Testimony of Shane McNamee, Medical Director, Richmond Polytrauma Rehabilitation Center, Department Of Veterans Affairs, hearing on *Servicemembers' Seamless Transition into Civilian Life — The Heroes Return*, in U.S. Congress, House Committee on Veterans Affairs, Subcommittee on Oversight and Investigations, 110th Cong., 1st sess., March 8, 2007.

⁶⁵ The President's Commission on Care for America's Returning Wounded Warriors, July (continued...)

by GAO, the Army and the Senior Oversight Committee's⁶⁶ workgroup on case management "have initiated efforts to develop case management approaches that are intended to improve the management of servicemembers' recovery process."⁶⁷ As of October 2007, VA, DOD, and the Department of Health and Human Services (HHS) have signed a memorandum of understanding to define the role of the Public Health Service in the Recovery Coordinator program. In addition, two members of the Public Health Service Commissioned Corps have been detailed from HHS to VA and are presently working with VA and DOD to establish the Recovery Coordinator (RC) program.⁶⁸

The RC would be designated by DOD and VA as the individual with delegated authority for oversight/coordination of the clinical and non-clinical care identified in the Individualized Recovery Plan (IRP) for every eligible severely injured/ill servicemember/veteran from initial admission to the MTF. The RC would (1) ensure the development, implementation, and oversight of the IRP and (2) ensure that the servicemembers/veterans and their families have access to all clinical and non-clinical case management services, including medical care, rehabilitation, education- and employment-related programs, and disability benefits.

According to the VA, the RC positions would be located at the following locations: Walter Reed Army Medical Center in Washington, DC; Bethesda Naval Medical Center in Bethesda, MD; Brooke Army Medical Center in San Antonio, TX; and Balboa Naval Medical Center in San Diego, CA.

VA Activities to Assist OEF and OIF Servicemembers

VA has stated that it has taken numerous steps to ease the transition of seriously injured servicemembers between DOD and VA medical facilities. VA has conducted several thousand briefings to servicemembers and their families about VA benefits and services, and about where to obtain VA health care services. VA also sends "thank-you" letters together with information brochures to each OEF and OIF veteran identified by DOD as having separated from active duty. These letters provide information on health care and other VA benefits, toll-free numbers for obtaining information, and appropriate VA websites for accessing additional information.

⁶⁵ (...continued)
2007, pp5-6.

⁶⁶ Senior Oversight Committee is an interagency committee specifically established to address concerns about the care and services provided to returning servicemembers. The committee is co-chaired by the Deputy Secretary of VA and the Deputy Secretary of Defense.

⁶⁷ U.S., Government Accountability Office (GAO), *DOD AND VA: Preliminary Observations on Efforts to Improve Health Care and Disability Evaluations for Returning Servicemembers*, GAO-07-1256T, p.8.

⁶⁸ Testimony of Patrick W. Dunne, Assistant Secretary for Policy and Planning, Department of Veterans Affairs, hearing on *VA and DOD Collaboration: Report of the President's Commission on Care For America's Returning Wounded Warriors; Report of the Veterans Disability Benefit Commission; and other related reports* in U.S. Congress, Senate Committee on Veterans' Affairs, October 17, 2007.

Letters and educational “tool kits” explaining VA services and benefits are also sent to each of the National Guard Adjutants General and the Reserve Chiefs. VA has stated that it has developed an outreach, education, and awareness program for the National Guard and Reserve. To ensure coordinated transition services and benefits, a Memorandum of Agreement (MOA) was signed with the National Guard in May 2005. VA is also in the process of developing MOAs with both the United States Army Reserve and the United States Marine Corps. According to VA these new partnerships will increase awareness of, and access to, VA services and benefits during the demobilization process and as service personnel return to their local communities.⁶⁹

VA-DOD Joint Executive Committee. The VA- DOD Joint Executive Committee (JEC) was established by the National Defense Authorization Act for 2004 (P.L. 108-136). The JEC is required to report annually to Congress with recommendations for improving coordination and sharing between the two departments. As part of preparing the recommendations, P.L. 108-136 requires the JEC to: (1) review all policies, procedures, and practices related to the coordination and sharing of resources between the departments; (2) identify changes to the policies, procedures, and practices that would benefit the coordination and sharing of resources between the agencies with the goal of improving the delivery of benefits and services; (3) identify further opportunities for coordination and collaboration between the departments that would not affect the quality of care, range of services, or priorities for benefits; (4) review each department’s plans for acquiring additional resources such as facilities, equipment, and technology to determine the effect on future opportunities for coordination and sharing of resources; and (5) review the implementation of activities designed to promote coordination and resource sharing between the departments. By statute, the JEC has at least two subordinate committees (for health and benefits), but may have other subordinate committees, or working groups, as deemed necessary by the Deputy Secretary of Veterans Affairs and the Under Secretary of Defense.⁷⁰ In April 2004, VA signed a Memorandum of Understanding (MOU) with DOD to provide health care and rehabilitation services to servicemembers who sustain spinal cord injury, TBI, or visual impairment. The MOU established referral procedures for transferring active duty inpatient servicemembers from DOD medical facilities to VA medical facilities.

Office of Seamless Transition. On January 3, 2005, VA established the National Veterans Affairs Office of Seamless Transition to ensure that there is no interruption of care as a servicemember moves from being a DOD patient to a VA patient, that whatever kinds of treatment are being delivered in the MTF are continued, and that treatment plans are shared. The office is composed of representatives from VHA, VBA, as well as an active duty Marine Corps officer from Marine4Life, a representative from the Army Wounded Warrior (AW2) program, and representatives from the National Guard and Reserve Components. The office also

⁶⁹ Testimony of Gordon H. Mansfield, Deputy Secretary, Department of Veterans Affairs hearing on *VA/DOD Cooperation and Collaboration* in U.S. Congress, Senate Committee on Veterans’ Affairs, 110th Cong., 1st sess., January 23, 2007.

⁷⁰ For more information on the JEC, see VA/DOD Joint Executive Council, *Fiscal Year 2006 Annual Report*, at [<http://www.tricare.mil/DVPCO/downloads/VADoD2006.pdf>].

facilitates priority access to care by enrolling patients in the VA system before they leave an MTF. Major activities of this office undertaken in 2006, are summarized below:

- Placed additional VA/DOD Liaisons at the Naval Medical Center in San Diego, California, and Womack Army Medical Center at Ft. Bragg, North Carolina.
- Placed a VA certified Rehabilitation Registered Nurse at the WRAMC to assess and provide regular updates to the Polytrauma Rehabilitation Centers on the medical condition of the patients, educate families and prepare the active duty servicemember for transition to the rehabilitation phase of recovery.
- Established an OIF/OEF Polytrauma Call Center to assist seriously injured veterans. The Call Center is operational 24 hours a day, 7 days a week to answer and/or refer clinical, administrative, and benefit inquiries from OIF/OEF polytrauma patients and their families.
- Trained 54 National Guard Transition Assistance Advisors (TAAs). TAAs would serve as the statewide point of contact and coordinator, to provide advice to Guard members, their families and all other reserves as to VA benefits and services, and to assist in resolving problems with VA healthcare, benefits, and TRICARE.⁷¹
- Implemented a seamless transition performance measure for FY2007. Under this performance measure severely injured OEF and OIF servicemembers who are transferred by VA/DOD Liaisons at the military treatment facilities must be assigned a VA medical center case manager prior to the transfer. This VA case manager must contact the service member/veteran within 7 calendar days of notification of the transfer.

Vet Centers. The Department has emphasized that it has enhanced its outreach efforts through the Vet Center program. This program was originally established by Congress in 1979 to meet the readjustment needs of veterans returning from the Vietnam War.⁷² From their inception, Vet Centers were designed to be community-based, non-medical facilities that offered easy access to care for Vietnam veterans who were experiencing difficulty in resuming a normal civilian life.

Today, VHA's Vet Center program consists of 209 community-based centers located across the country, and in Puerto Rico, the Virgin Islands, and Guam. On February 7, 2007, the Department announced that it will be establishing 23 new centers in communities across the nation during 2007 and 2008.⁷³ The Vet Center

⁷¹ TRICARE is the health plan of the military health system. For detailed information about this program see, CRS Report RL33537, *Military Medical Care: Questions and Answers*, by Richard A. Best Jr.

⁷² Established by the Veterans' Health Care Amendments of 1979 (P.L. 96-22).

⁷³ New Vet Centers will be located in Montgomery, Alabama; Fayetteville, Arkansas; Modesto, California; Grand Junction, Colorado; Orlando, Fort Myers, and Gainesville, (continued...)

program is primarily funded through the Medical Services appropriation (personnel costs), with additional funds provided from the Medical Facilities (leasing costs), Information Technology, and Medical Administration accounts. Vet Center funding is designated as specific purpose funding within the overall medical care appropriation. Funds are allocated at the direction of the Readjustment Counseling program office.

Each Vet Center is managed by a Team Leader who reports to one of the seven Readjustment Counseling Service (RCS) Regional Managers. The Chief Readjustment Counseling Officer at the VA Central Office is responsible for direct line supervision, through the seven RCS Regional Managers, of all Vet Center clinical and administrative operations. The Chief Readjustment Counseling Officer reports directly to the Under Secretary for Health.

Site selection for the new Vet Centers is based on demographic data from the U.S. Census Bureau and the DOD Defense Manpower Data Center. Initial input is provided by the seven RCS Regional Offices. Finally, recommendations and supporting data are evaluated by the Chief Readjustment Counseling Officer and the Office of the Under Secretary for Health. The final decision is made by the Under Secretary for Health. Vet Centers utilize permanently leased space and are usually staffed by one or two counselors who provide full-time services to area veterans on a regular basis. Vet Centers also remain open after normal business hours or on weekends to accommodate veterans traveling in from greater distances.

Vet Centers have hired and trained 100 new outreach workers from among the ranks of recently separated OIF and OEF veterans. In May 2007, VHA announced that it plans to recruit an additional 100 staff positions to the Vet Center program in FY2008 and another 100 staff positions for FY2009. Vet Center outreach is primarily for the purpose of providing information that will facilitate a seamless transition and the early provision of VA services to newly returning veterans and their family members upon separation from the military. These positions are being located on or near active military out-processing stations, as well as National Guard and Reserve facilities. New veteran hires are providing briefing services to transitioning servicemen and women regarding military-related readjustment needs, as well as the complete spectrum of VA services and benefits available to them and their family members. VA also has stated that it expects to add staff to 61 existing facilities to augment the services these centers provide.⁷⁴

⁷³ (...continued)

Florida; Macon, Georgia; Manhattan, Kansas; Baton Rouge, Louisiana; Cape Cod, Massachusetts; Saginaw and Iron Mountain, Michigan; Berlin, New Hampshire; Las Cruces, New Mexico; Binghamton, Middletown, Nassau County and Watertown, New York; Toledo, Ohio; Du Bois, Pennsylvania; Killeen, Texas; and Everett, Washington. During 2007, VA plans to open facilities in Grand Junction, Orlando, Cape Cod, Iron Mountain, Berlin and Watertown. The other new Vet centers are scheduled to open in 2008.

⁷⁴ Testimony of Acting Under Secretary for Health Department of Veterans Affairs Dr. Michael J. Kussman, in U.S. Congress, House Committee on Veterans' Affairs Subcommittee on Oversight and Investigations, hearing on *Servicemembers' Seamless* (continued...)

All combat veterans are eligible for Vet Center readjustment counseling services.⁷⁵ From FY2003 through the end of the third quarter of FY2007, the Vet Center program has provided services to 183,530 veterans and clinical services to 58,504 veterans.⁷⁶ The Vet Center program also provides bereavement counseling services to family members of those servicemembers killed while on active. From FY2003 through the end of the third quarter of FY2007, such services have been provided to more than 1,570 family members. In addition, the Vet Centers provide counseling to veterans who have experienced sexual trauma while on active duty.

Exchange of Health Information. As discussed previously, a key component of the seamless transition of patients from DOD to the VA is the exchange of medical information between the two Departments. Since the late 1990s, VA and DOD have been working toward an interoperable medical record.⁷⁷ Before OEF and OIF, VA and DOD had been focusing on unidirectional exchange of information from DOD to VA, which would have helped VA understand the care provided to veterans while they were in the military. In June 2005, a memorandum of understanding (MOU) was signed between DOD and VA for the purposes of defining data sharing between the two departments. This MOU provides the necessary governance for the sharing of protected health information and other individually identifiable information. Later, the two Departments decided to implement a bi-directional exchange of medical information (Bidirectional Health Information Exchange — BHIE) to include information on patients' allergies, lab and radiology results, and pharmacy data. Both Departments have deployed the BHIE interface. This new interface allows VA providers to access information from all DOD health care facilities, and allows providers at all military treatment facilities to access BHIE directly from DOD's electronic medical record system. To facilitate the transfer of servicemembers from DOD treatment facilities to VA Polytrauma Rehabilitation Centers, scans of patients' radiology and medical records are now being transferred to the VA's integrated imaging system.

At present, the Clinical Health Data Repository interface is being tested in several DOD and VA locations. This interface would support the exchange of data elements in real time rather than transmitting batches of data at regular intervals. **Figure 9** shows the current and planned health information exchanges between the two Departments.

⁷⁴ (...continued)

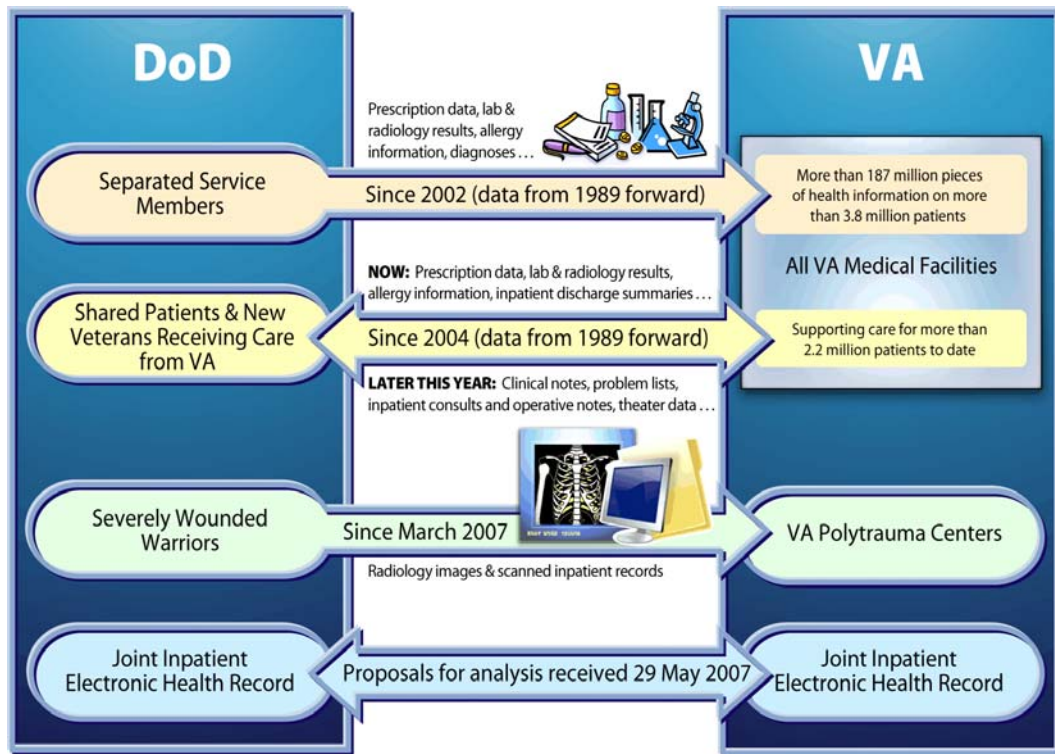
Transition into Civilian Life — The Heroes Return, 110th Cong., 1st sess., March 8, 2007.

⁷⁵ For a list of who is eligible for Vet Center services, see [<http://www.va.gov/RCS/Eligibility.asp>].

⁷⁶ Testimony of Under Secretary for Health, Department of Veterans Affairs, Dr. Michael J. Kussman, in U.S. Congress, House Committee on Veterans' Affairs, hearing on the *Long-Term Costs of the Current Conflicts*, 110th Cong., 1st sess., October 17, 2007.

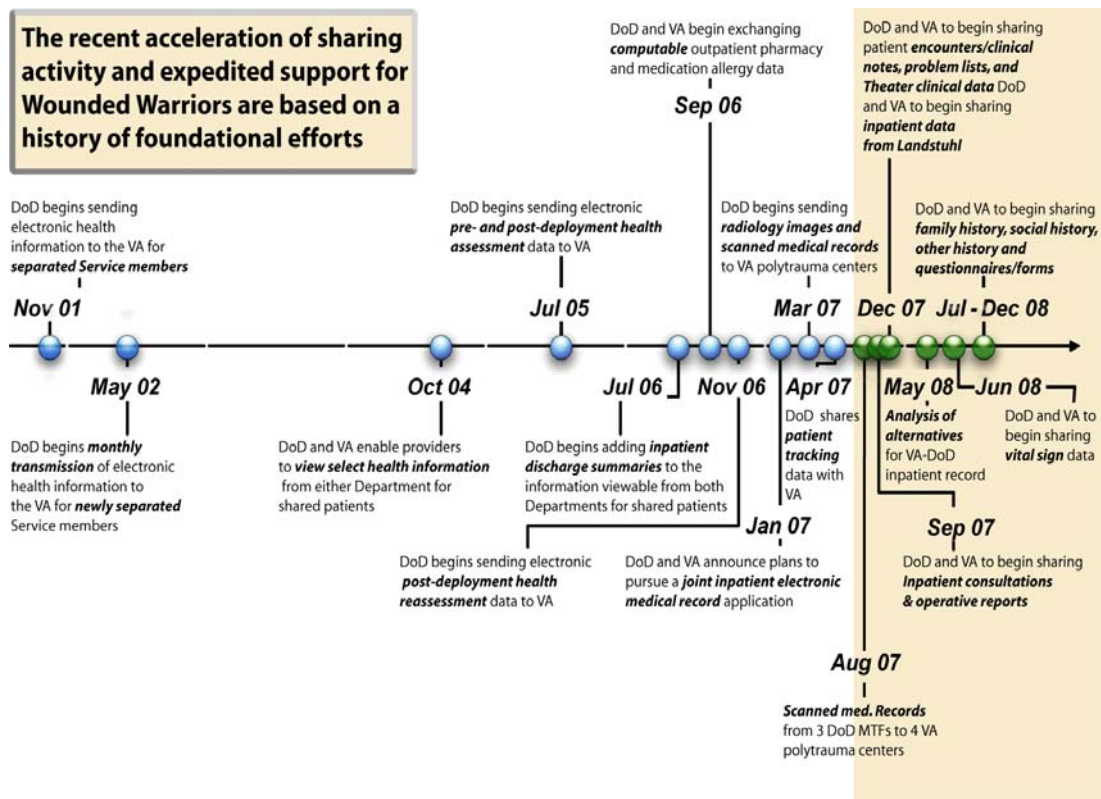
⁷⁷ In 1996, the President's Advisory Committee on Gulf War Veterans' Illnesses reported on many deficiencies in VA's and DOD's data capabilities for handling servicemembers' medical records. In November 1997, the President called for the two departments to start developing a comprehensive, lifelong medical record for each service member. In 1998 the President issued an executive order requiring VA and DOD to develop a "computer-based patient record system that will accurately and efficiently exchange information."

Figure 9. DOD and VA Electronic Information Sharing Focus Areas



Source: DOD presentation to CRS, July 10, 2007, adapted by CRS Graphics.

The full timeline and critical milestones supporting the exchange of medical information between the VA and the DOD are depicted in **Figure 10**.

Figure 10. Milestones and Plans for Exchange of Medical Information

Source: DOD presentation to CRS, July 10, 2007, adapted by CRS Graphics

Veterans Tracking Application (VTA). The VTA was activated on Monday, April 23, 2007.⁷⁸ VTA would provide access to medical records in real time on wounded soldiers evacuated from Afghanistan and Iraq. Prior to this only VA's four polytrauma centers were able to access this information. The VA liaisons at the DOD MTFs and the point of contacts at the VA medical centers would now be able to use VTA to track the referral of patients from the DOD MTFs such as Walter Reed Army Medical Center to VA medical centers. According to VA, clinicians would continue to access clinical data on OEF and OIF servicemembers being treated in their facilities through DOD's Joint Patient Tracking Application (JPTA)⁷⁹ or through VTA.

The VA has stated that by the end of 2007, it expects that data in VTA will be available to providers through VistA. This VistA interface would assure that VA

⁷⁸ Bob Brewin, "VA to debut new patient tracking system," *Government Executive*, April 20, 2007. Available at [<http://www.govexec.com/dailyfed/0407/042007br1.htm>].

⁷⁹ The Joint Patient Tracking Application (JPTA) was created primarily as an electronic record for tracking where a patient was in the military healthcare system when moving from the battlefield to a field hospital to Landstuhl, Germany, and then on to Military Treatment facilities in the US. Although there has been some medical information inserted into the JPTA, including X-rays and scans done in theater, JPTA is not a complete medical record.

providers get VTA data in a format with which they are familiar and would reduce the training burden on the providers in the field.

Two-Year Eligibility for Veterans Returning from Iraq and Afghanistan. Veterans who have served or are now serving in Iraq and Afghanistan may, following separation from active duty, enroll in the VA health care system and, for a two-year period following the date of their separation, receive VA health care without copayment requirements for conditions that are or may be related to their combat service. Following this initial two-year period, they may continue their enrollment in the VA health care system but may become subject to any applicable copayment requirements.⁸⁰ For information on legislation to expand eligibility, see section on veterans health care legislation below.

Task Force on Returning Global War on Terror Heroes. On February 18, 2007, the Washington Post reported the first in a series of articles describing problems with outpatient medical care and other services provided at the Walter Reed Army Medical Center (a DOD facility in Washington, DC) to injured servicemembers returning from combat theaters in support of OEF and OIF.⁸¹ In response to these the President appointed several task forces and study panels to report on ways to improve services to returning servicemembers and reduce bureaucratic delays. On April 19, 2007, the interagency task force chaired by VA Secretary Nicholson issued a report providing 25 recommendations to improve delivery of federal services to returning military men and women. A summary of the health care recommendations is given below:⁸²

- Develop a system of co-management and case management for returning servicemembers to facilitate ease of transfer from DOD care to VA care.
- Screen all OEF and OIF veterans seen in VA health care facilities for mild to moderate TBI.

⁸⁰ The Veterans Programs Enhancement Act of 1998 (P.L. 105-368) [38 U.S.C. § 1710(e)(1)(D) and § 1710(e)(3)(C)] authorized VA to provide health care for an initial two-year period after discharge from service for veterans (including National Guard and Reserve components) in combat during any period of war after the first Gulf War or during any other future period of hostilities after November 11, 1998, even if there is insufficient medical evidence to conclude that such illnesses are attributable to such service. For combat veterans who do not enroll with VA during the two-year post-discharge period, eligibility for enrollment and subsequent health care is subject to such factors as a service-connected disability rating, VA pension status, catastrophic disability determination, or financial circumstances (as described in this report). If their financial circumstances place them in Priority Group 8, they will be “grandfathered” into a Priority Group 8a or Priority Group 8c, and their enrollment in VA will be continued, regardless of the date of their original VA application.

⁸¹ Dana Priest and Anne Hull, “Soldiers Face Neglect, Frustration At Army’s Top Medical Facility,” *Washington Post*, February 18, 2007.

⁸² The Task Force on Returning Global War on Terror Heroes, Report to the President, p. 3.

- Assist the VA enrollment process by modifying the VA 10-10EZ form for returning servicemembers, enhance the on-line benefits package to self-identify OEF and OIF servicemembers, and expand the use of DOD military service information to establish eligibility for health care benefits.
- Require VA to provide full support at Post-Deployment Health Reassessments for Guard and Reserve members to enroll eligible members and schedule appointments.
- Standardize VA Liaison agreements across all military treatment facilities.
- Expand VA access to DOD records to coordinate improved transfer of a servicemember's medical care through patient "hand-off."
- Enhance the Computerized Patient Record System (CPRS) to more specifically track OEF and OIF servicemembers.
- Develop a Veterans Tracking Application (VTA) and identifiers to improve monitoring of returning servicemembers (the VTA was activated in April 2007).
- Create an "Embedded Fragment" surveillance center to monitor returning servicemembers who have possibly retained fragments of materials (shrapnel etc.) in order to provide early medical intervention.
- Enhance capacity for OEF and OIF servicemembers to receive dental care in the private sector as VA continues to improve their capacity for dental services at their facilities.
- Expand collaboration between VA and the Department of Health and Human Services to improve access to returning servicemembers in remote or rural areas.
- Expand coordination on IT interoperability with the goal to adopt standardized data sharing between the VA and Indian Health Service (IHS) health care partners.

Other Health Care Issues

Post-Traumatic Stress Disorder (PTSD)

PTSD is the most prevalent mental disorder among returning OEF and OIF servicemembers and has drawn the most attention. Congress has held hearings about mental health care services provided by VA to these returning servicemembers. Demand for mental health services, including treatment for PTSD, is likely to grow not only from new soldiers returning from active combat, but also among veterans experiencing increased levels of anxiety and mental stress during wartime.⁸³

OEF/OIF PTSD Data and Trends. As of June, 30 2007, VHA facilities have examined a total of 56,246 OEF and OIF veterans for potential PTSD. This

⁸³ Alan West and William Weeks, "Veterans Before, During, and After the Invasion of Iraq," *Psychiatric Services*, vol. 57, no. 2 (February 2006).

includes inpatient, outpatient, and Vet Center visits. Of these veterans, 48,559 have received a possible diagnosis of PTSD.

The hallmark characteristics of PTSD include flashbacks, nightmares, intrusive recollections or re-experiencing of the traumatic event, avoidance, numbing, and hyperarousal. When such symptoms last under a month, they are typically associated with acute stress disorder, not PTSD. In order for a diagnosis of PTSD, symptoms have to persist for at least a month and cause significant impairment in important areas of daily life.

PTSD is known to have high rates of comorbidity with other anxiety disorders, major depressive disorder and substance abuse. Some studies indicate that more than 80% of people with PTSD also experience a major depressive or other psychiatric disorder.⁸⁴ Studies investigating rates of comorbidity for PTSD and lifetime prevalence of alcohol abuse have indicated rates from 68% of individuals with PTSD to as high as 82%.⁸⁵

VA treatment programs for PTSD. Within the VA, programming for mental health is driven by the Mental Health Strategic Plan (MHSP). The goal of MHSP is to anticipate need and fill in the gaps of current mental health programs based on the CARES model (Capital Asset Realignment for Enhanced Services, discussed later in the report) and recommendations from the President's New Freedom Commission on Mental Health.

The VA delivers mental health services in a variety of clinical settings and specialized programs. Specifically, VA provides PTSD services in medical facilities, community settings, and Vet Centers. The VA medical centers include a network of more than 100 specialized programs for veterans suffering from PTSD. Outpatient PTSD programs offer three types of clinics where veterans meet with mental health professionals and PTSD specialists. PTSD Day Hospital Programs provide a "therapeutic community" offering social, recreational and vocational activities in addition to counseling throughout the week. Inpatient programs provide PTSD treatment in hospital units with 24-hour psychiatric and nursing care.

Beginning in 2005, VHA created Returning Veterans Education and Clinical Teams in medical centers to help, educate, evaluate, and treat returning veterans with mental health and psychosocial issues. These programs collaborate with other VAMC PTSD, substance abuse and mental health programs, and with polytrauma, TBI and primary care services, as well as with Vet Centers. By the close of FY2007 VA anticipates that it would have 90 of these programs operational throughout the country.

⁸⁴ National Academies, Institute of Medicine, *Posttraumatic Stress Disorder: Diagnosis and Assessment*, 2006.

⁸⁵ National Academies, Institute of Medicine, *Posttraumatic Stress Disorder: Diagnosis and Assessment*, 2006, p.13.

Traumatic Brain Injury (TBI)

OEF/OIF TBI Data. Among the more than 22,600 U.S. soldiers wounded in the conflicts in Iraq, Afghanistan, and other locations as of November 4, 2006, blasts from Improvised Explosive Devices (IEDs) have been by far the most common cause of injury, and 59% of blast-exposed patients at Walter Reed have been found to have a TBI.⁸⁶ On April 14, 2007, the VA began screening veterans who had seen service in Iraq or Afghanistan since the beginning of October 2001 for symptoms that may be associated with TBI.⁸⁷ Of the 61,285 veterans that VA has screened for TBI to date, 11,804 (19.26%) screened positive for TBI symptoms. At present, VA clinicians are further evaluating these 11,804 to determine whether they have actually suffered a TBI or whether the symptoms they exhibit are due to other causes, such as PTSD or other combat-related stress. A representative sample of 127 recently completed evaluations indicated that 41 veterans received a definitive diagnosis of TBI, suggesting that about one-third (32.28%) of the veterans who screen positive have actually suffered a traumatic brain injury.

TBI is the result of a severe or moderate force to the head, where physical portions of the brain are damaged and functioning is impaired. Common problems after TBI include headache, decreased memory, slow mental processing, poor attention, inability to tolerate sound, sleep disturbance, and irritability. Closely related to cognitive impairment are emotional issues such as PTSD, depression, and anxiety disorders. These psychological issues often interact with the physical injury to decrease patients' overall health status and adherence to medical regimens. Those who experience TBI may behave impulsively because of damage that removes many of the brain's checks on the regulation of behavior. Without the limits provided by these higher brain functions, these individuals may overreact to seemingly innocent or neutral stimuli.⁸⁸

The outcome of TBI is particularly relevant for understanding PTSD because the amnesia that often occurs with TBI challenges the role of traumatic recollections in the etiology of PTSD. Studies have shown that in the absence of factual recall, individuals have delusions or reconstruct memories of trauma. These individuals

⁸⁶ Susan Okie, "Traumatic Brain Injury in the War Zone," *New England Journal of Medicine*, Vol. 352, pp. 2043-2047 May 19, 2005; and "Reconstructing Lives — A Tale of Two Soldiers," *New England Journal of Medicine*, volume 355 pp. 2609-2615 December 21, 2006.

⁸⁷ The instrument used to screen veterans is a highly sensitive, not specific, questionnaire. The questionnaire is designed to identify everyone who may possibly have suffered a TBI. It should be noted that some of those who are identified by this questionnaire as possibly having a TBI will not, in fact, receive that diagnosis upon a subsequent in-depth evaluation.

⁸⁸ Drawn from Henry L. Lew, Guest Editorial, "Rehabilitation needs of an increasing population of patients: Traumatic brain injury, polytrauma, and blast-related injuries," *Journal of Rehabilitation Research & Development*, volume 42, no. 4 July/August 2005.

may retain the delusional memories better than the factual events. Hence, traumatic recall does not have to be accurate or factual to be part of PTSD.⁸⁹

VA Treatment of TBI. The four VA polytrauma centers in Minneapolis, Palo Alto, Richmond, and Tampa provide care to those with TBI. These facilities were designated as polytrauma centers because of their experience in medical and rehabilitative care for patients with TBI and other traumatic conditions, as well as their collaborative status with the national Defense and Veterans Brain Injury Centers (these are facilities that coordinate treatment and research for traumatic brain injuries affecting active-duty military, and veterans).⁹⁰

Mandatory Funding for Veterans' Health Care

Veterans' advocates say that the unpredictable timing, if not uncertain funding amounts inherent in the yearly discretionary appropriations process, is a major management problem for the VA. Furthermore, veterans' groups have stated that Congress's failure to enact appropriations bills by the beginning of the fiscal year adds further strain on the VA health care system, by postponing the hiring of new medical staff, foregoing medical facility maintenance and repairs, and thereby compromising on the quality of health care provided to veterans. Therefore, national veterans' organizations have been calling for "assured funding" for veterans' health care. This has also been called "mandatory funding" by other veterans' advocates. This discussion will use mandatory funding to refer to these policy proposals.

To understand mandatory funding proposals, it is essential to understand how VA programs are funded presently. Under current law, VA programs are funded through both mandatory and discretionary spending authorities. The following programs are among mandatory spending programs: cash benefit programs, that is, compensation and pensions (and benefits for eligible survivors); readjustment benefits (education and training, special assistance for disabled veterans); home loan guarantees; and veterans' insurance and indemnities. Each of these programs is an appropriated entitlement that is funded through annual appropriations.⁹¹ With any entitlement program, because of the underlying law, the government is required to provide eligible recipients with the benefits to which they are entitled, whatever the cost. Congress is obliged to appropriate the money necessary to fund the obligation.

⁸⁹ Peleg T, Shalev AY, "Longitudinal Studies of PTSD: Overview of Findings and Methods," *CNS Spectrum*, vol 11, no. 8, pp. 589-602, 2006.

⁹⁰ Defense and Veterans Brain Injury Centers are located at Walter Reed Army Medical Center, Washington, DC; Wilford Hall US Air Force Medical Center, Lackland Air Force Base, TX; Brooke Army Medical Center, Fort Sam Houston, TX; Naval Medical Center-San Diego, San Diego, CA; Hunter McGuire VA Medical Center, Richmond, VA; James A Haley VA Hospital, Tampa, FL; Veterans Affairs Medical Center, Minneapolis, MN; VA Palo Alto Health Care System, Palo Alto, CA; and Lakeview Virginia NeuroCare, Charlottesville, VA (Civilian Partner Site). Further information available at [<http://www.dvbic.org/index.html>].

⁹¹ For a detailed explanation on appropriated entitlements, see CRS Report RS20129, *Entitlements and Appropriated Entitlements in the Federal Budget Process*, by Bill Heniff Jr.

If the amount Congress provides in the annual appropriations act is not enough, it is obliged to make up the difference in a supplemental appropriation. Like other entitlement programs, spending automatically increases or decreases over time as the number of recipients eligible for benefits varies. Certain of these VA entitlement benefits are indexed for inflation; the benefit amount will increase automatically based on the measured increase in the cost-of-living adjustment.

The remaining VA programs, primarily health care, medical facility construction, medical research, and VA administration, are funded through annual discretionary appropriations. Each year, Congress takes up the matter of providing budget authority for discretionary programs. As such, the amount of funds VHA can spend on discretionary programs is determined by the amount of its appropriation.

Generally, the mandatory funding proposals that have been suggested by veterans' advocates are based on a formula that takes into account the number of enrolled and nonenrolled veterans eligible for VA medical care, and the rate of medical care inflation. Proponents believe that mandatory funding will eliminate the year-to-year uncertainty about funding levels and close the gap between funding and demand for veterans' health care. Opponents believe that with these proposals spending for VHA will increase significantly as enrollment in the VA health care system soars; in most of the proposed funding formulas, automatic funding increases are primarily based on enrollment figures. Furthermore, critics believe that a static funding formula cannot adequately take into consideration the changing needs of veterans, which could affect the funding level necessary to provide a different mix of services, and that Congress is better able to evaluate the funding needs through the current annual appropriation process. For instance, not all enrolled veterans use the VA health care system in a given year. Should the number of users grow in one year and the number of enrollees remain stagnant, no additional funding would be available for the additional patients with increased utilization of health care services.

During a hearing in the 109th Congress, Chairman Buyer of the House Veterans' Affairs Committee stated that "[a]ccording to the Congressional Budget Office [CBO], mandatory funding would cost nearly half-a-trillion dollars over ten years. That would be a costly experiment. In contrast, the strong discretionary budgets of the past decade have proven responsive to change"⁹² However, CBO stated that "although the bill would primarily affect funding for health care services provided by VHA, it also would result in some savings in direct spending for other government programs, primarily Medicare and Medicaid."⁹³

As highlighted by some budget analysts, changing veterans' medical care into a mandatory budget authority may not solve the issue of closing the gap between funding and demand for veterans' health care. Congress can place caps on spending for mandatory programs through budget reconciliation language, which would limit

⁹² House Committee on Veterans' Affairs, "Committee Hears Legislative Views of Millions of Veterans," press release, September 20, 2006.

⁹³ U.S. Congressional Budget Office, Cost Estimate, H.R. 515 (109th Congress), Assured Funding for Veterans Health Care Act of 2005, July 25, 2005, p.1.

spending on veterans' health programs.⁹⁴ Since Congress can act to change the formula or cap the spending amounts, the issue of uncertainty in funding amounts may not be resolved either. In recent testimony before the House Veterans Affairs Committee, Henry J. Aaron of the Brookings Institution stated that "converting the VHA to mandatory funding would not entirely insulate it from budgetary pressures. Congress could cut the per person funding amount or exclude certain groups of veterans from the formula used for computing annual funding."⁹⁵

The Veterans Health Care Full Funding Act (H.R. 1041), Mandatory Funding for Veterans Act of 2007 (H.R. 1382), Assured Funding for Veterans Health Care Act (H.R. 2514) have been introduced in the 110th Congress. H.R. 1041 would require appropriations for VA health care to be funded based on recommendations proposed by an independent Veterans Health Care Funding Review Board. H.R. 1382 and H.R. 2514 would require the Secretary of the Treasury to make mandatory appropriations for VA health care based on a formula.

Continued Suspension of Priority Group 8 Veterans

Veterans' advocates want the suspension of Priority Group 8 veterans from enrolling in VA's health care system lifted, since they believe that all veterans must be able to receive care from VA. As discussed earlier, the Veterans Health Care Eligibility Reform Act of 1996 (P.L. 104-262) included language that stipulated that medical care to veterans will be furnished to the extent appropriations were made available by Congress on an annual basis. Based on this statutory authority, the Secretary of Veterans Affairs announced on January 17, 2003, that VA would temporarily suspend enrolling Priority Group 8 veterans.⁹⁶ Those who were in VA's health care system prior to January 17, 2003, were not to be affected by this suspension. VA claims that, despite its funding increases, it cannot provide all enrolled veterans with timely access to medical services because of the tremendous increase in the number of veterans seeking care from VA.⁹⁷

Table 4 provides data from FY2003 through August 2006 on the number of Priority Group 8 veterans who applied for enrollment and were unable to enroll, and provides cumulative estimates from FY2006 thru FY2008. As seen in **Table 4**, the VA estimates that if the suspension on enrollment were to be lifted in FY2008, almost 1.6 million Priority Group 8 veterans would be eligible to enroll in the VA health care system.

⁹⁴ Testimony of Richard Kogan, Center on Budget and Policy Priorities at the Alternative Processes for Funding Veterans Health Care Forum, June 3, 2004. Transcript available at [http://www.dav.org/voters/mandatory_funding.html].

⁹⁵ U.S. Congress, House Committee on Veterans Affairs, hearing on *Funding the U.S. Department of Veterans Affairs of the Future*, 110th Congress, 1st sess., October 3, 2007.

⁹⁶ Department of Veterans Affairs, "Enrollment — Provision of Hospital and Outpatient Care to Veterans Subpriorities of Priority Categories 7 and 8 and Annual Enrollment Level Decision; Final Rule," 68 *Federal Register* 2670, January 17, 2003.

⁹⁷ For detailed information on the FY2007 veterans health care budget see, CRS Report RL33409, *Veterans' Medical Care: FY2007 Appropriations*, by Sidath Viranga Panangala.

Table 4. Impact of Priority Group 8 Suspension, FY2003-FY2008

FY2003 cumulative	FY2004 cumulative	FY2005 cumulative	2006 cumulative through August 2006	FY2006 cumulative estimate	FY2007 cumulative estimate	FY2008 cumulative estimate
93,228	192,419	263,257	327,457	830,203	1,254,460	1,570,503

Source: Department of Veterans Affairs.

The number of Priority Group 8 veterans already enrolled in VA's health care system is expected to decline from 1.27 million in FY2005 to 1.22 million in FY2006; this is mostly due to projected death rates for these veterans and the continued suspension of new enrollments.⁹⁸ In 2004, VA estimated that resumption of enrollment for Priority Group 8 veterans would require an additional \$519 million over the FY2005 requested VHA budget, and an estimated \$2.3 billion in FY2012.⁹⁹ The Senate Veterans Affairs Committee estimates that \$1.113 billion would be needed to restore access for Priority Group 8 veterans. According to the Committee this number is based on VA's own estimates of what it would cost to reopen the system to Priority Group 8 veterans.¹⁰⁰

Congress has shown a keen interest in providing access to VHA care for Priority Group 8 veterans, and legislation has been introduced to lift the suspension (H.R. 463, and a companion measure S. 1147). Provisions from S. 1147 have been incorporated into S. 1233 (see section on "Health Care Legislation Reported in the Senate" below).

Filling of Privately Written Prescriptions at VA

As part of VA's comprehensive medical care benefits package, VA provides all veterans who are enrolled for VA care with appropriate prescription medications, at the nominal charge of \$8 for a 30-day supply per prescription. In general, the copayments are waived if the prescription is for a service-connected condition, if the veteran is severely disabled or indigent, or if the veteran was a former Prisoner of War (POW). VA dispenses medications, however, only to those veterans who are enrolled for, and who actually receive VA-provided care. Generally, VA does not provide medications to veterans unless those medications are prescribed by a physician who is employed by or under contract with VA.

⁹⁸ Department of Veterans Affairs, *FY2006 Budget Submission, Medical Programs*, vol. 2 of 4, pp. 2-4.

⁹⁹ U.S. Congress, Senate Committee on Appropriations, *Department Veterans Affairs, and Housing and Urban Development and Independent Agencies Appropriations for FY2005*, hearings on H.R. 5041/S. 2825, 108th Cong., 2nd sess., April 6, 2004, S.Hrg. 108-776, p. 379.

¹⁰⁰ Democratic and Independent Members of the Committee on Veterans' Affairs Views and Estimates on the FY2008 budget for Function 700 (Veterans' Benefits and Services), March 1, 2007.

However, there are two exceptions to this general requirement. VHA is required to provide medications, upon the order of any licensed physician, to: 1) veterans receiving additional disability compensation under Chapter 11 of Title 38 of the United States Code (U.S.C.), as a result of being permanently housebound or in need of regular aid and attendance due to a service-connected condition, or veterans who were previous recipients of such compensation and in need of regular aid and attendance; and 2) veterans receiving nonservice-connected pensions under Chapter 15 of Title 38 U.S.C. as a result of being permanently and totally disabled from a nonservice-connected disability, and who are permanently housebound or in need of regular aid and attendance.¹⁰¹

To address the growing waiting lists for primary care and specialty care appointments and to reduce the waiting times for a first appointment, VA implemented a program in September 2003 to provide access to VA prescription drugs for veterans experiencing long waits for their initial primary care appointment. This temporary program was known as the Transitional Pharmacy Benefit (TPB). Under this program, VA pharmacies and VA's Consolidated Mail Outpatient Pharmacies (CMOPs) were authorized to fill prescriptions written by non-VA (private) physicians until a VA physician could examine the veteran and determine an appropriate course of treatment. The TPB included most, but not all, of the drugs listed on the VA National Formulary (VANF).¹⁰² To be eligible for the program, veterans had to be enrolled in the VA health care system prior to July 25, 2003, and had to have requested their initial primary care appointment prior to July 25, 2003. To qualify for this program, veterans also must have been waiting more than 30 days for the initial primary care appointment as of September 22, 2003.

Although VA anticipated that around 200,000 veterans would be eligible to participate in the program, about 41,000 veterans were ultimately deemed eligible to enroll; of those veterans, about 8,300 veterans participated. VA attributes low participation to the fact that many veterans had already received VA services by the start of the program. According to the VA, the TPB program incurred administrative costs associated with contacting private physicians to suggest formulary alternatives, as many of them had prescribed medications that were not on VA's formulary. VA has discontinued this pilot program.

There was considerable interest in the 108th and 109th Congresses in providing a prescription-only health care benefit for veterans. While several bills were introduced, none of them was enacted into law.

Capital Asset Realignment for Enhanced Services (CARES)

VA holds a substantial inventory of real property and facilities throughout the country. A majority of these buildings and property support VHA's mission. Much of VA's medical infrastructure was built decades ago when its focus was inpatient care. In the past several years VA has been shifting from a hospital-based system

¹⁰¹ 38 U.S.C. § 1712(d); 38 C.F.R. §17.96.

¹⁰² A formulary is a list of drugs approved for coverage under a drug benefit.

and, today, more than 80% of the treatment VA provides is on an outpatient basis through Community Based Outpatient Clinics (CBOCs). In 1999, GAO projected that one in four medical care dollars was spent on maintaining and operating VA's buildings and land. It estimated that VA has over 5 million square feet of vacant space which can cost as much as \$35 million a year to maintain.¹⁰³

In October 2000, VA established the CARES program with the goal of evaluating the projected health care needs of veterans over the next 20 years, and of realigning VA's infrastructure to better meet those needs. In August 2003, VA's Under Secretary for Health issued a preliminary *Draft National CARES Plan* (DNCP). The DNCP, among other things, recommended that seven VA health care facilities be closed and duplicative clinical and administrative services delivered at over 30 other VHA facilities be eliminated. The sites slated to be closed were in: Canandaigua, New York; Pittsburgh, Pennsylvania (Highland Drive Division); Lexington, Kentucky (Leestown Division); Cleveland, Ohio (Brecksville Unit); Gulfport, Mississippi; Waco, Texas; and Livermore, California. Patients currently provided services at these VHA facilities would be provided care at other nearby sites. The DNCP recommended that new major medical facilities be built in Las Vegas, Nevada, and in East Central Florida. Furthermore, the DNCP recommended significant infrastructure upgrades at numerous sites, including at or near locations where VA proposed to close facilities. In addition, the draft plan called for the establishment of 48 new high-priority CBOCs.

Following the release of the DNCP, the VA Secretary appointed a 16-member independent commission to study the draft plan. The commission was composed of individuals from a wide variety of backgrounds outside of the federal government. The CARES Commission developed and applied six factors in the review of each proposal in the DNCP: (1) impact on veterans' access to health care; (2) impact on health care quality; (3) veteran and stakeholder views; (4) economic impact on the community; (5) impact on VA missions and goals; and (6) cost to the government. The commission conducted 38 public hearings and 81 site visits throughout 2003, and submitted its recommendations to the Secretary in February 2004. After reviewing the recommendations, the Secretary announced the final details of the CARES plan in May 2004 (Secretary's CARES Decision). **Table 5** provides a timeline of major activities under the CARES process.

The final plan included consolidating the following facilities: (1) Highland Drive campus in Pennsylvania with University Drive and Heinz campuses in Pennsylvania; (2) Brecksville campus in Ohio with Wade Park campus in Cleveland, Ohio; and (3) Gulfport campus with Biloxi campus in Mississippi. The following facilities were to be partially realigned: (1) Knoxville campus in Iowa; (2) Canandaigua campus in New York; (3) Dublin campus in Georgia; (4) Livermore campus in California; (5) Montrose campus in New York; (6) Butler campus in

¹⁰³ U.S. General Accounting Office, *VA Health Care: Capital Asset Planning and Budgeting Need Improvement*, GAO/T-HEHS-99-83, March 10, 1999, pp. 1-6.

Pennsylvania; (7) Saginaw campus in Michigan; (8) Ft. Wayne campus in Indiana; and (9) Kerrville campus in Texas.¹⁰⁴

The final plan also called for building new hospitals in Orlando and Las Vegas; adding 156 new CBOCs, four new spinal cord injury centers, and two blind rehabilitation centers; and expanding mental health outpatient services nationwide. By opening health care access to more veterans, VA expects to increase the percentage of enrolled veterans from 28% of the veterans' population today, to 30% in 2012 and 33% in 2022. This percentage increase can be attributed in part to a projected decline in the overall veteran population. Nationally, the number of veteran enrollees is projected to increase 6% by 2012 and decrease 5% by 2022 from the number of veteran enrollees reported in 2001. VA asserts that the CARES plan will reduce the cost of maintaining vacant space over the period 2006 to 2022 from an estimated \$3.4 billion to \$750 million and allow VA to redirect those funds to patient care.¹⁰⁵

¹⁰⁴ The Draft National CARES Plan (DNCP) defines realignment as: moving services from one facility to another, contracting for care to ensure inpatient access to care is available when needed, and in all cases maintaining outpatient services in the community.

¹⁰⁵ Department of Veterans Affairs, Office of the Secretary, Secretary of Veterans Affairs, *CARES Decision*, May 2004, pp. 1-8.

Table 5. Timeline of Major CARES Activities

Date	Activity	Description
February 2002	VA announced the results of a pilot CARES study.	The pilot study assessed current and future use of health care assets in the three markets of Network 12, which includes parts of five states: Illinois, Indiana, Michigan, Minnesota, and Wisconsin. It resulted in decisions to realign health care services and renovate or dispose of several buildings consistent with VA mission and community zoning issues.
August 2003	VA's Under Secretary for Health presented the Draft National CARES Plan.	The Under Secretary's Draft National CARES Plan included recommendations about health care services and capital assets in VA's remaining 74 markets. These recommendations reflected input from managers of VA's health care networks.
February 2004	An independent CARES Commission issued recommendations.	An independent 16-member commission appointed by the Secretary of Veterans Affairs issued recommendations to the Secretary based on its review of the Draft National CARES Plan and related documents and information obtained through public hearings, site visits, public meetings, written comments from veterans and other stakeholders, and consultations with experts.
May 2004	VA's Secretary announced the CARES decisions.	The Secretary based his decisions on a review of the CARES Commission's recommendations.
January 2005	CARES follow-up studies.	VA awarded a contract for additional studies at 18 VA facilities. These studies will include evaluating outstanding health care issues, developing capital plans, as well as determining the best use for unneeded VA property consistent with VA mission and community zoning issues.

Source: Government Accountability Office, *VA Health Care: VA Should Better Monitor Implementation and Impact of Capital Asset Alignment Decisions*, GAO-07-408, March 2007.

Critics of the CARES plan contend that closures are being considered without assessing what kind of facilities will be needed for long-term care and mental health care in the future. For instance, at the time of the release of the DNCP, projections for outpatient and acute psychiatric inpatient care contained data inconsistencies on future needs. VA asserted that it would improve its forecasting models to ensure that projections adequately reflect future need. Also, some believe that the CARES plan

does not focus enough on future nursing home needs, and would leave VA short of beds in a few decades. In this view, VA would not have any choice but to privatize some parts of the health care system. Moreover, some veterans' groups believe that CARES is only about closing "surplus" hospitals and do not believe that CARES will result in the building of new and modern facilities. Finally, the closure of some VA medical facilities raised serious concern among some Members of Congress who felt that they had little input into the CARES process.¹⁰⁶

The Veterans Health Programs Improvement Act of 2004 (P.L. 108-422), signed into law on November 30, 2004, required VA to notify Congress of the impact of actions that may result in a facility closure, consolidation, or administrative reorganization. The law also prohibits such actions from occurring until 60 days following the notification.

The Secretary's CARES Decision identified implementation issues that required further study, including additional stakeholder input at selected sites. On September 29, 2004, the Secretary of VA established an Advisory Committee for CARES Business Plan Studies. The committee and its subcommittees generally consist of representatives from veterans' service organizations, governmental agencies, health care providers, planning agencies, and community organizations with a direct interest in the CARES process. This committee is to consult with stakeholders during implementation of the Secretary's CARES Decision. The committee is to ensure that the full range of stakeholder interests and concerns are assembled, publicly articulated, accurately documented, and considered in the development of site-level business plans.

In January 2005, VA awarded a contract to PricewaterhouseCoopers to complete studies at 18 sites throughout the country during a 13-month period, as required by the Secretary's CARES Decision.¹⁰⁷ Local Advisory Panels (LAPs) gathered views of stakeholders regarding the range of potential options provided by the contractor and made recommendations to the Secretary. In 2006 VA announced the Secretary's decision for some of the 18 sites. For some sites decisions have not yet been announced.

VA has begun implementing some of the projects under the CARES decisions. Specifically, as of February 2007, VA was in the process of implementing 32 of more

¹⁰⁶ Honorable Bob Graham, "Statements on Introduced Bill and Joint Resolutions," remarks in the Senate, *Congressional Record*, 108th Congress, vol. 149 (June 18, 2003), p. S8135.

¹⁰⁷ The 18 sites are Boston, MA (VISN 1); Canandaigua, NY (VISN 2); Montrose, NY (VISN 3); New York City, NY (VISN 3); St. Albans, NY (VISN 3); Perry Point, MD (VISN 5); Montgomery, AL (VISN 7); Louisville, KY (VISN 9); Lexington, KY (VISN 9); Poplar Bluff, MO (VISN 15); Biloxi, MS (VISN 16); Muskogee, OK (VISN 16); Waco, TX (VISN 17); Big Spring, TX (VISN 18); Walla Walla, WA (VISN 20); White City, OR (VISN 20); Livermore, CA (VISN 21); West LA, CA (VISN 22).

than 100 major capital projects that were identified in the CARES process.¹⁰⁸ Given below in **Table 6** is a summary of the final decisions announced thus far.

Table 6. CARES Decisions on the 18 Sites

Study Site	CARES Decision
Boston, MA (VISN 1)	The contractor’s final report proposed closing four Boston VAMCs and creating a single medical center for the metropolitan area. The Secretary rejected this proposal and has instructed the contractor to proceed to Stage 2 and provide more detailed analysis of several other options. The additional options include shifting inpatient psychiatry and long-term care from the Bedford VAMC facility to the Brockton VAMC, while retaining outpatient care at Bedford and consolidating services currently located at West Roxbury VAMC into the Jamaica Plain VAMC, or vice versa.
Canandaigua, NY (VISN 2)	After reviewing the contractor’s final report, the Secretary rejected all proposals to move services to an off-site facility. The Secretary decided to construct a new single-floor, 120-bed nursing home and a new 50-bed residential rehabilitation facility and to renovate the outpatient building. VA will also explore partnerships with the private sector to generate revenue and complementary services for veterans by leasing under-used buildings and land. As required by the Military Quality of Life, Military Construction, Veterans Affairs, and Related Agencies Appropriations Act FY2006 (P.L. 109-114, H.Rept. 109-305), VA has designated the Canandaigua VAMC as a mental health and post traumatic stress disorder (PTSD) “Center of Excellence,” and has housed its National Suicide Prevention Hot Line at Canandaigua.
Montrose/Castle Point, NY (VISN 3)	Based on the contractor’s final report, the VA decided to maintain the current residential treatment program and build a multi-specialty ambulatory care facility at the Montrose campus. Furthermore, VA would completely modernize the Castle Point campus.
New York City, NY (VISN 3)	Based on the contractor’s final report, the Secretary has decided to retain the existing VAMCs in both Brooklyn and Manhattan.
St. Albans, NY (VISN 3)	Based on the contractor’s final report, the Secretary has decided that VA would replace existing facilities at St. Albans with a new nursing home, outpatient clinics and a domiciliary consolidated on the north end of the campus.

¹⁰⁸ Government Accountability Office, *VA Health Care: VA Should Better Monitor Implementation and Impact of Capital Asset Alignment Decisions*, GAO-07-408, March 2007.

Study Site	CARES Decision
Perry Point, MD (VISN 5)	After reviewing the contractors report and the recommendations of the Local Advisory Panel (LAP) the Secretary decided to build a new nursing home and modernize existing mental health and outpatient facilities. VA will continue the study internally to complete a capital plan for the campus. There will be no Stage 2 study.
Montgomery, AL (VISN 7)	Based on the contractor's final report, the Secretary has decided to continue inpatient services at the Montgomery facility.
Louisville, KY (VISN 9)	Based on the contractor's final report, a new medical center will replace the current facility. VA's Office of Facility Management has created a site selection board, and is in the process of selecting an architectural and engineering firm to support the analysis of site locations.
Lexington, KY (VISN 9)	After reviewing the contractor's final report, the Secretary requested the contractor to proceed to Stage 2 and provide a more detailed study of two options selected by the Secretary. The first option is to replace all facilities on the southeastern part of the Leestown facility; and the second option is to construct appropriately sized new clinical care buildings on the central portion of the Leestown facility.
Poplar Bluff, MO (VISN 15)	After reviewing the contractor's report and the recommendations of the Local Advisory Panel (LAP) the Secretary decided to maintain inpatient services and added cardiology services to the existing list of services. The Secretary's decision rejected the option for the closure of Poplar Bluff inpatient services, and referral of inpatient VA care to a community hospital.
Biloxi, MS (VSIN 16)	Hurricane Katrina obviated the need for this study because the facility was destroyed. Future construction requirements are being addressed through emergency appropriations in response to Hurricane Katrina.
Muskogee, OK (VISN 16)	After reviewing the contractor's recommendations the Secretary decided to maintain inpatient services at the Muskogee VAMC and to expand psychiatric services.
Waco, TX (VISN 17)	The Military Quality of Life, Military Construction, Veterans Affairs, and Related Agencies Appropriations Act FY2006 (P.L. 109-114, H.Rept. 109-305) required VA to designate Waco VAMC as a mental health and PTSD "Center of Excellence." The Secretary decided to keep the facility open.
Big Spring, TX (VISN 18)	The contractor's final report did not recommend the closure and transfer of inpatient care, stating that the Big Spring VAMC is in good condition, quality of care is excellent and change would result in no improvements to access. Therefore, the Secretary decided that inpatient services will remain at the Big Spring VAMC.

Study Site	CARES Decision
Walla Walla, WA (VISN 20)	After reviewing the contractor's final report, the Secretary rejected options to close the Walla Walla VAMC and move the services to the Tri-Cities market. VA would replace the current Walla Walla VAMC with a new multi-specialty outpatient facility and ensure that inpatient and nursing home services are available.
White City, OR (VISN 20)	After reviewing the contractor's final report, the Secretary has decided that VA will not transfer services from the White City Southern Oregon Rehabilitation Center and Clinic (SORCC). However, VA will continue to evaluate if it will renovate or replace the current facility.
Livermore, CA (VISN 21)	After reviewing the contractor's final report, the Secretary requested the contractor to proceed to Stage 2 and provide a more detailed study of three options selected by the Secretary. The first option is to construct a new nursing home on the current site, the second option is to relocate the current nursing home care unit to a new off-site stand-alone facility co-located with ambulatory care services. The third option is to renovate the current nursing home unit and consolidate all necessary logistics and support functions.
West LA, CA (VISN 22)	After reviewing the contractor's final report, the VA has decided to completely modernize the inpatient facility for outpatient services. In addition, a new VA building to place the urns containing the remains of cremated veterans, and a new facility for the Veterans Benefits Administration Regional Office, will be housed on campus. Buildings 205, 208, and 209 have been designated for homeless veterans programs.

Source: CRS analysis of VA decision announcements.

Beneficiary Travel Program

In general, the beneficiary travel program reimburses certain veterans for the cost of travel to VA medical facilities when seeking health care. P.L. 76-432, passed by Congress on March 14, 1940, mandated VA to pay either the actual travel expenses, or an allowance based upon the mileage traveled by any veteran traveling to and from a VA facility or other place for the purpose of examination, treatment, or care. P.L. 85-857, signed into law on September 2, 1958, authorized VA to pay necessary travel expenses to any veteran traveling to or from a VA facility or other place in connection with vocational rehabilitation counseling or for the purpose of examination, treatment, or care. However, this law changed VA's travel reimbursement into a discretionary authority by stating that VA "may pay" expenses of travel.

Due to rapidly increasing costs of the beneficiary travel program, on March 12, 1987, VA published final regulations that sharply curtailed eligibility for the

beneficiary travel program.¹⁰⁹ Under these regulations beneficiary travel payments to eligible veterans were paid when specialized modes of transportation, such as ambulance or wheelchair van, were medically required. In addition, payment was authorized for travel in conjunction with compensation and pension examinations, as well as travel beyond a 100-mile radius from the nearest VA medical care facility. It also authorized the VA to provide transportation costs, when necessary, to transfer any veteran from one health care facility (either a VA or contract care facility) to another in order to continue care paid for by the VA. The following transportation costs were not authorized under these regulations:

- Cost of travel by privately owned vehicle in any amount in excess of the cost of such travel by public transportation unless public transportation was not reasonably accessible or was medically inadvisable.
- Cost of travel in excess of the actual expense incurred by any person as certified by that person in writing.
- Cost of routine travel in conjunction with admission for domiciliary care, or travel for family members of veterans receiving mental health services from the VA except for such travel performed beyond a 100-mile radius from the nearest VA medical care facility.

Travel expenses of all other veterans were not authorized unless the veterans were able to present clear and convincing evidence to show the inability to pay the cost of transportation; or except when medically-indicated ambulance transportation was claimed and an administrative determination was made regarding the veteran's ability to bear the cost of such transportation.¹¹⁰

The Veterans' Benefits and Services Act of 1988 (P.L. 100-322, section 108), in large part restored VA travel reimbursement benefits. It required that if VA provides any beneficiary travel reimbursement under Section 111 of Title 38 U.S.C. in any given fiscal year, then payments must be provided in that year in the case of travel for health care services for all the categories of beneficiaries specified in the statute. In order to limit the overall cost of this program, the law imposed a \$3 one-way deductible applicable to all travel, except for veterans otherwise eligible for beneficiary travel reimbursement who are traveling by special modes of transportation such as ambulance, air ambulance, wheelchair van, or to receive a compensation and pension examination. In order to limit the overall impact on veterans whose clinical needs dictate frequent travel for VA medical care, an \$18-per-calendar-month cap on the deductible was imposed for those veterans who are pre-approved as needing to travel on a frequent basis. At present, eligible veterans are reimbursed at the rate of 11 cents a mile for routine visits and 17 cents a mile for compensation and pension exams. Although the deductible rates are set in statute, the mileage rates are left to the discretion of the Secretary. **Table 7** provides details on veterans who are currently eligible to receive travel benefits.

¹⁰⁹ Veterans Administration, "Transportation of Claimants and Beneficiaries," final regulations, 52 FR 7575-01, March 12, 1987. These regulations became effective on April 13, 1987.

¹¹⁰ Ibid.

Table 7. Veterans Eligible for Travel Benefits

- Veterans with service-connected disabilities rated 30% or more.
- Veterans with service-connected disabilities rated less than 30% traveling for treatment of a service-connected condition.
- Veterans in receipt of a VA pension.
- Veterans traveling for a compensation or pension (C&P) exam.
- Veterans whose income does not exceed the maximum annual VA pension rate with an additional aid and attendance allowance.

With the rise in gasoline prices Congress has shown interest in changing the method of determining the mileage reimbursement rate and/or eliminating the current deductible amount. S. 1233, as reported in the Senate, includes a provision that would require the VA to reimburse qualifying veterans at the particular rate authorized by the Administrator of General Services, for federal government employees traveling on official business.

Veterans Health Care Legislation

Health Care Legislation Enacted into Law

Joshua Omvig Veterans Suicide Prevention Act (H.R. 327, H.Rept. 110-055, P.L. 110-110). The House passed this measure on March 21, 2007, and the Senate passed the House measure with an amendment on September 27. The bill was signed into law on November 5, 2007. P.L. 110-110, would, among other things, require the VA to establish a comprehensive program for suicide prevention among veterans. In carrying out this comprehensive program, the VA must designate a suicide prevention counselor at each VA medical facility. Each counselor is required to work with local emergency rooms, police departments, mental health organizations, and veterans service organizations to engage in outreach to veterans. The Act also requires the VA to provide for research on best practices for suicide prevention among veterans. P.L. 110-110 requires the Secretary to provide for outreach and education for veterans and the families of veterans, with special emphasis on providing information to veterans of OIF and OEF and the families of such veterans. The Act requires VA to provide for the availability of 24-hour mental health care for veterans and to establish a 24-hour hotline for veterans to call if needed. (In July 2007, the VA established a national suicide prevention hotline for veterans. The toll-free number, 1-800-273-TALK [8255], is staffed by mental health professionals 24 hours a day, 7 days a week).

Health Care Legislation Passed by the House¹¹¹

Returning Servicemember VA Healthcare Insurance Act of 2007(H.R. 612). The House passed this bill on May 23, 2007. H.R. 612 as amended, would extend the eligibility period from two years to five years following discharge or release for veterans who served in combat during or after the Persian Gulf War, to receive hospital care, medical services, or nursing home care provided by the VA, without having to prove that their condition is attributable to such service. H.R. 612 also provides for an additional three years of eligibility for veterans discharged more than five years before the enactment of this Act who have not enrolled.

Chiropractic Care Available to All Veterans Act (H.R. 1470). The House passed H.R. 1470 on May 23, 2007. The measure would require that chiropractic services be made available in not fewer than 75 VAMCs by the end of December 2009, and at all health care centers by the end of 2011.

Traumatic Brain Injury Health Enhancement and Long-Term Support Act of 2007 (H.R. 2199, H.Rept. 110-166). The House passed this measure on May 23, 2007. H.R. 2199, as amended, would require mandatory screening of veterans for traumatic brain injury (TBI). It would also require the VA to establish a comprehensive program of care for post-acute traumatic brain injury rehabilitation. H.R. 2199, as amended, would require the VA to establish TBI transition offices at each Department polytrauma network site to coordinate health care and services to veterans who suffer from moderate to severe traumatic brain injuries. Furthermore, the measure, as passed by the House, would require the VA to establish a registry of those who served in Operation Enduring Freedom or Operation Iraqi Freedom (OEF or OIF) who exhibit symptoms associated with TBI. H.R. 2199 also includes two provisions to improve the quality of care provided to rural veterans. It would create an advisory committee on rural veterans and establish a pilot program to provide readjustment counseling, related mental health services, and benefits outreach, through mobile Vet Centers.

Veterans Benefit Improvement Act of 2007 (H.R. 1315, H.Rept. 110-266). This measure was passed by the House on July 30, 2007. Among other things, this bill contains a provision that would require the VA to establish a Vision Education Scholarship Program under the Health Professional Education Assistance Program. Those who receive a scholarship award would be required to work for three years in a VA health care facility. H.R. 1315 also mandates the Secretary to provide financial assistance to students enrolled in a program of study leading to a degree or certificate in blind rehabilitation in a U.S. state or territory, provided they agree with applicable requirements. The purpose of this scholarship is to increase the supply of qualified blind rehabilitation specialists for the VA.

Veterans Health Care Improvement Act of 2007 (H.R. 2874, H.Rept. 110-268). This bill was passed on July 30, 2007. Among other things, H.R. 2874 would allow VA to establish a grant program for nonprofit entities to conduct

¹¹¹ For benefit legislation, see CRS Report RL33985, *Veterans' Benefits: Issues in the 110th Congress*, by Carol D. Davis, Coordinator.

workshops to assist in the therapeutic readjustment and rehabilitation of OEF and OIF veterans. The amount of the grants would be limited to \$100,000 for each calendar year, and there would be \$2 million authorized each fiscal year to carry out the program. The grant program would terminate on September 30, 2011. It would also require the VA to establish a grant program for rural veterans service organizations, state veterans' service agencies, and nonprofits to provide innovative transportation options to veterans in remote rural areas to travel to VA medical facilities. Grant amounts would be limited to \$50,000, and the bill authorizes \$3 million for each fiscal year from 2008 to 2012 to carry out the program.

H.R. 2874 would permanently authorize VA's authority to provide higher priority health care to veterans who participated in Project Shipboard Hazard and Defense (SHAD), Project 112, or related land-based tests. Under current law, VA is authorized to provide higher priority health care to these veterans with any illness, without those veterans needing an adjudicated service-connected disability to establish their priority for care. This special treatment authority will expire on December 31, 2007. This measure would also extend through September 30, 2009, VA's authority to require certain nonservice-connected veterans to pay a \$10 per diem copayment when they receive VA hospital care, and extend through October 1, 2009, VA's authority to bill a service-connected patient's third-party insurance carrier for the cost of care VA provides the veteran for any nonservice-connected condition.

H.R. 2874 would also require VA to provide readjustment counseling and mental health services for OEF and OIF veterans. Such services would include contracting with community mental health centers in areas not adequately served by VA and contracting with nonprofit mental health organizations to train OEF and OIF veterans in outreach and peer support. It also directs VA to conduct training programs for clinicians that have contracts with VA to provide such services. It would also require the VA to ensure that VA domiciliary programs are adequate in capacity and safety to meet the needs of women veterans.

Furthermore, H.R. 2874 would reduce the time that a homeless veteran would have to wait to receive dental treatment from 60 days to 30 days. Under current law, VA can provide dental services to eligible homeless veterans as long as they have been receiving care for a period of 60 consecutive days in a domiciliary, therapeutic residence, community residential care coordinated by VA, or a setting for which the VA provides funds for a grant and per diem provider.

Prohibit the collection of copayments for all hospice care provided by the VA (H.R. 2623, H.Rept. 110-267). H.R. 2623 was passed by the House on July 30. This bill would exempt all hospice care provided through VA from copayment requirements. Under current law, a veteran receiving hospice care in a nursing home is exempt from any applicable copayments. However, if the hospice care is provided in any other setting, such as in an acute-care hospital or at home, the veteran may be subject to an inpatient or outpatient primary care copayment. By exempting all hospice care provided by the VA regardless of the setting, H.R. 2623 would align the VA health care system with the Medicare program, which does not impose copayments for hospice care regardless of the setting.

Health Care Legislation Reported in the Senate

Veterans Traumatic Brain Injury and Health Programs Improvement Act of 2007 (S. 1233, S.Rept. 110-147). S. 1233, as amended, was ordered to be reported by the Senate Veterans' Affairs Committee on June 27, 2007.¹¹² This bill includes several provisions related to enhancing veterans health care. As reported, S. 1233 would require VA to develop individual rehabilitation and community reintegration plans for veterans and servicemembers with TBI who are being treated in the VA health care system. The plan would identify a case manager to oversee its long-term implementation and would specify dates for review of the plan. The bill would also authorize the VA to use non-VA facilities for the implementation of rehabilitation and community reintegration plans for traumatic brain injury under certain specified circumstances. S. 1233, as reported, would require VA to develop and implement a research, education, and clinical care program on severe TBI. It also would authorize a five-year pilot program on assisted living services for veterans with traumatic brain injury and would require the VA to provide age-appropriate nursing home care for veterans who suffer from severe TBI

The Veterans Programs Enhancement Act (P.L. 105-368) authorized priority eligibility for health care for a period of two years following discharge or release from active duty to any veteran who served in a combat theater of operations. S. 1233 would extend the period from two to five years. According to the committee report (S.Rept. 110-147), this extension is necessary to ensure that veterans returning from combat receive health care during their transition from military service to civilian life and to address health care issues such as PTSD, which may take years to manifest. S. 1233 would require VA to establish a Hospital Quality Report Card Initiative to inform veterans and their families of the quality and performance of VA hospitals. According to S.Rept. 110-147, "the initiative is intended to help veterans and their families to make informed health care choices."¹¹³

S. 1233, as reported in the Senate, would require the VA to annually — by August 1 — to publish a notice in the *Federal Register* of which categories of veterans are eligible to be enrolled in VA health care in the upcoming fiscal year. Furthermore, in any year in which the VA proposes to stop enrollment, the VA Secretary would be required to provide to the House and Senate VA Committees an estimate of the cost of enrolling all eligible veterans. After the notice is published, the VA would be required to wait 45 days before implementing any change in enrollment. According to the committee report, "this notice-and-wait requirement would provide Congress with an opportunity to oversee the enrollment of veterans in the Veterans Health Administration, and to respond to any proposed limitation on enrollment."¹¹⁴ Furthermore, it is the view of the committee that when resources are

¹¹² S. 1233 contained provisions from the following bills: S. 117, S. 383, S. 472, S. 692, S. 874, S. 994, S. 1026, S. 1146, S. 1147, S. 1326, S. 1384, S. 1392, and S. 1396.

¹¹³ U.S. Congress, Senate Committee on Veterans' Affairs, *Veterans' Traumatic Brain Injury and Other Health Programs Improvement Act of 2007*, report to accompany S. 1233, 110th Congress, 1st sess., S.Rept. 110-147, p. 12.

¹¹⁴ *Ibid*, p. 13.

provided by Congress to enable the VA to keep pace with demand for services, the VA health care system should be open to all veterans who seek care.¹¹⁵

S. 1233 would require the VA to establish a grant program to provide transportation options to veterans in rural areas. Under this grant program, VA would provide grants for rural veterans' service organizations and community-based organizations to provide transportation to veterans in remote rural areas. For each of FY2008 through FY2012, \$6 million would be authorized to be appropriated for this grant program. The grants would be awarded to state veterans' service agencies, veterans service organizations, and qualified community transportation organizations.

Among other things, S. 1233 would require VA to establish demonstration projects on alternatives for expanding care for veterans in rural areas. Under the committee-reported measure, two demonstration projects would be required to be carried out in geographically dispersed areas. It would require VA to partner with the Department of Health and Human Services (HHS) and the Indian Health Service (IHS) to expand care for Native American veterans.

Furthermore, S. 1233 would exempt veterans in Priority Group 4 (veterans who have been determined by the VA to be catastrophically disabled) from paying copayments for nonservice-connected hospital care or nursing home care. Under current law, these veterans are required to pay copayments for all nonservice-connected care they receive from the VA.

S. 1233, as reported in the Senate, would increase reimbursement rates for travel to VA medical facilities. At present, eligible veterans are reimbursed at the rate of 11 cents a mile for routine visits and 17 cents a mile for compensation and pension exams. Under S 1233, the VA would reimburse qualifying veterans at the particular rate authorized for government employees under section 5707(b) of Title 5 U.S.C.

On November 14, 2007, the Senate Veterans' Affairs Committee ordered the following bills reported without amendment: S. 2004 (to amend Title 38 U.S.C. to establish epilepsy centers of excellence in the Veterans Health Administration of the Department of Veterans Affairs), S. 2142 (the Veterans Emergency Care Fairness Act of 2007), S. 2160 (The Veterans Pain Care Act of 2007), and S. 2162 (Mental Health Improvements Act of 2007). The committee has not released the Committee Print versions of these bills.

¹¹⁵ Ibid.

Appendix. Priority Groups and Their Eligibility Criteria

Priority Group 1
Veterans with service-connected disabilities rated 50% or more disabling
Priority Group 2
Veterans with service-connected disabilities rated 30% or 40% disabling
Priority Group 3
Veterans who are former POWs
Veterans awarded the Purple Heart
Veterans whose discharge was for a disability that was incurred or aggravated in the line of duty
Veterans with service-connected disabilities rated 10% or 20% disabling
Veterans awarded special eligibility classification under Title 38, U.S.C., Section 1151, “benefits for individuals disabled by treatment or vocational rehabilitation”
Priority Group 4
Veterans who are receiving aid and attendance or housebound benefits
Veterans who have been determined by VA to be catastrophically disabled
Priority Group 5
Nonservice-connected veterans and noncompensable service-connected veterans rated 0% disabled whose annual income and net worth are below the established VA means test thresholds
Veterans receiving VA pension benefits
Veterans eligible for Medicaid benefits
Priority Group 6
Compensable 0% service-connected veterans
World War I veterans
Mexican Border War veterans
Veterans solely seeking care for disorders associated with
— exposure to herbicides while serving in Vietnam; or
— ionizing radiation during atmospheric testing or during the occupation of Hiroshima and Nagasaki; or
— for disorders associated with service in the Gulf War; or
— for any illness associated with service in combat in a war after the Gulf War or during a period of hostility after November 11, 1998.
Priority Group 7
Veterans who agree to pay specified copayments with income and/or net worth <i>above</i> the VA means test threshold and income <i>below</i> the HUD geographic index
Subpriority a: Noncompensable 0% service-connected veterans who were enrolled in the VA Health Care system on a specified date and who have remained enrolled since that date
Subpriority c: Nonservice-connected veterans who were enrolled in the VA health care system on a specified date and who have remained enrolled since that date.
Subpriority e: Noncompensable 0% service-connected veterans not included in Subpriority a above
Subpriority g: Nonservice-connected veterans not included in Subpriority c above
Priority Group 8
Veterans who agree to pay specified copayments with income and/or net worth <i>above</i> the VA means test threshold and the HUD geographic index
Subpriority a: Noncompensable 0% service-connected veterans enrolled as of January 16, 2003, and who have remained enrolled since that date
Subpriority c: Nonservice-connected veterans enrolled as of January 16, 2003, and who have remained enrolled since that date
Subpriority e: Noncompensable 0% service-connected veterans applying for enrollment after January 16, 2003

Source: Department of Veterans Affairs